MidAmerican ENERGY®

Life Support Program Enrollment

This enrollment form is to be completed by the customer of record and a registered attending physician. Once enrolled, MidAmerican Energy will send an information packet and attempt notification prior to scheduled interruptions in electric service for the area due to repairs, upgrades to our system, etc. Completion of this form does NOT allow for priority in restoration of utility services and does NOT prevent disconnection for non-payment. If the individual using life-support equipment cannot be without power for any reason, MidAmerican recommends developing alternate care plans. Please consult with your physician and/or medical equipment supplier regarding your particular medical needs.

MidAmerican Energy exercises reasonable diligence in supplying continuous electrical services. Under no circumstance is the company a guarantor or insurer of uninterruptible service. For example, there are numerous situations where conditions beyond our control can result in power outages. All service is restored following an interruption as soon as practical. The Company will not be liable for any injury, loss or damage resulting from interruption, shortage or insufficiency of service or irregularities of service.

TO BE COMPLETED BY CUSTOMER:

MidAmerican Energy Account Number_____
(Can be found on bill)

Name of Patient_____Date of Birth:___/___/____

Relationship to Customer of Record:_____

Address _____
Street/P.O. Box City State Zip Code

Emergency Contact Name (person NOT residing at the residence):_____

Emergency Contact Phone Number: (____)_____

Customer Signature:_____

TO BE COMPLETED BY PHYSICIAN:

Physician Name _____Hospital Affiliation _____

Address _____
Street/P.O. Box City State Zip Code

Phone Number (_____)_____ Fax Number (_____)_____

Type of Device:

- ❑ Infant Apnea Monitor
- ❑ Ventilator/Respirator
- ❑ Home Dialysis
- ❑ IV Pumps
- ❑ Oxygen Concentrator (does not include nebulizer)
- ❑ BIPAP (Bi-level Positive Airway Pressure)
- ❑ C-Pap Machine – Minor Child (Continuous Positive Airway Pressure)
- ❑ LVAD (Left Ventricular Assist Device)

How often is the device used?_____

How long is the device used for each treatment?_____

I acknowledge the patient listed above requires the life-support equipment noted above.

Physician Signature _____Date ___/___/___

Mail: Life Support Program, MidAmerican Energy, P.O. Box 4350, Davenport, IA 52808
Fax: 563-333-8690