



Phone: 816-471-5275
Fax: 816-654-1139

Date Sent _____
Please Return Within 30 Days

MEDICAL CUSTOMER APPLICATION

IF ACCEPTED, A RENEWAL APPLICATION WILL BE SENT ANNUALLY. ACCEPTANCE INTO THE MEDICAL CUSTOMER PROGRAM DOES NOT GUARANTEE CONTINUOUS ELECTRICAL SERVICE NOR DOES IT PREVENT COLLECTION ACTIVITY FOR UNPAID ELECTRIC BILLS. A CUSTOMER WHOSE SERVICE IS CRITICAL FOR LIFE SUPPORT SHOULD MAKE PRIOR EMERGENCY ARRANGEMENTS TO ACCOMMODATE THE MEDICAL PATIENT DURING POWER INTERRUPTIONS.

TO BE FILLED IN BY CUSTOMER

Customer Name _____					Account Number _____	
Street Address _____		City & State _____	Zip Code _____	Home Phone _____	Work Phone _____	
Special Friend Notification, in case we cannot reach the customer (Name and Phone Number) _____					Cell Phone _____	
Patient's Name _____		Birth Date _____	Physician's Name _____		Telephone _____	

Authorization: I hereby authorize release of any medical information including direct consultation with any physicians that is pertinent to my qualifying as a medical customer with Kansas City Power and Light Company. By signing below, applicant acknowledges the accuracy and truth of the information provided. **For your protection the law requires you to be advised of the following:** It is a criminal act to make a false or fraudulent claim, or assist in the preparation or presentation of a false or fraudulent claim. Violators of this provision may be subject to criminal prosecution.

Signature of Patient or Legal Guardian _____					Date _____	
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TO BE FILLED IN BY PHYSICIAN

PLEASE RESPOND TO THE FOLLOWING ISSUES:

Nature of Ailment _____ Is the patient bedfast? YES _____ NO _____

Is electrically-powered medical equipment required to sustain life? YES _____ NO _____ If so, what type of equipment? _____

Will the absence of electricity result in an immediate life-threatening situation? YES _____ NO _____ If so, how? _____

Is the medical equipment **capable** of being operated by battery-supplied electricity? YES _____ NO _____

How often is the medical equipment used? _____

Have you advised your patient of the action to take in case his or her medical equipment fails to operate for any reason? YES _____ NO _____

If so, what is the plan of action? _____

Is the patient's condition temporary? Yes _____ NO _____ If so, when will the condition warrant removal from medical customer list? _____

Additional Comments: _____

Physician's Name (Please Print) _____		Office Address _____	(_____) _____	Phone _____
Physician's Signature _____		City, State, Zip Code _____		Date _____

FOR KCP&L USE ONLY

APPROVED: REJECTED BY: _____ DATE: _____