Notice of Potential Medically Dependent Customer Form

This form is to be completed by the **account holder, patient** and a **medical practitioner** to confirm that the patient is:

a. using mains electricity dependent critical electrical medical equipment (CEME); and
b. at some point in the future may be dependent on the CEME to the extent that disconnection may result in loss of life or serious harm.

Upon confirmation that the CEME is supplied or prescribed by the DHB, Private Hospital or a General Practitioner, the patient will be placed on Pulse Energy's Medical Dependency Register.

This certification applies from:

If dependency on mains electricity is temporary, this certification is valid until (optional)

ACCOUNT HOLDER DETAILS			
Black Box Power Account Holder Details	Full Name:		Date of Birth:
	Account Number:		
Patient Name			
Patients Permanent Residence Address			
Patient Contact Details	Home Ph:	Work Ph:	Mobile Ph:
	E-mail:		

In the event that Black Box Power is unable to contact the account holder and/or patient (if different) to discuss this medical dependency, please provide an alternative emergency contact.

EMERGENCY CONTACT DETAILS		
Emergency Contact Name		
Emergency Contact Address		
Emergency Contact Details	Home Ph:	Mobile Ph:
	Work Ph:	Other Ph:

Consent: As the recipient of this medical equipment and a potentially medically dependent consumer, I consent to Black Box Power using my account details, the information on this form and information on the future status of my dependence on the medical equipment to be shared between:

a. Health Practitioner(s) and with DHB
b. Electricity Retailers
c. Other third-party Electricity contractors
d. Electricity Network Companies
e. Electricity Account Holder
f. The Authorised Contact
g. The Ministry of Social Development if the account is in arrears and payment arrangements have failed to be made or kept

Signed (Patient) _____ Date: _____

Signed (Account Holder)[1] _____ Date: _____

[1] *Only required where the patient is not the Account Holder. This must be the person named as "Account Holder" in Account Holder Details above.*

Please complete both sides

REGISTERED MEDICAL PRACTITIONER TO COMPLETE		
Medical Practitioner		Registration No.
Designation (General Practitioner, Specialist)		
Contact Details	Work Ph:	Mobile Ph:
	E-mail:	
	Postal Address:	

CONFIRMATION ELECTRICITY IS REQUIRED

I _____ (Medical Practitioner) certify that _____ (patient's name) with NHI number _____ is:

a. using mains electricity dependent critical electrical medical equipment (CEME); and
b. at some point in the future may be dependent on the CEME to the extent that disconnection may result in loss of life or serious harm.

I also certify that the patient listed above has been provided knowledge, training and support in accordance with appropriate clinical practice:

a. for the use of CEME; and
b. what to do in an emergency, including when the supply of electricity may be interrupted for any reason.

Signed: _____ Date: _____
Medical Practitioner's Stamp/Seal

MEDICAL CONDITION DETAILS	
Medical Condition(s)[2]:	
Type of critical medical equipment[3] requiring a continuous supply of electricity	

[2] The medical condition(s) must require critical medical support. Critical medical support is defined as support which, in the opinion of a DHB, private hospital or GP, is required to prevent loss of life or serious harm.

[3] Critical electrical medical equipment is defined as any equipment supplied or prescribed by a DHB, private hospital or GP, which requires mains electricity to provide critical medical support to a person, and includes other electrical equipment need- ed to support either the critical medical equipment or the treatment regime.

Duration for which equipment will be required:	☐ Permanently require equipment ☐ Temporarily require equipment Reference Number: _____ Expiry date: _____

Please post a copy of this completed form to Black Box Power, PO Box 10044, Dominion Road, Auckland 1446

If you wish to add additional notes or information, please attach to this form or write details below. *(optional)*