

**APPLICATION TO BLUE RIDGE MOUNTAIN EMC
FOR
MEDICAL EQUIPMENT EXEMPTION**

Please Print

BRMEMC Service Address	Account Number: -
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Customer's Name	Mailing Address	Phone Number:
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Patient's Name	Phone#
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CUSTOMER

I hereby attest that I am responsible for payment of the BRMEMC billing of utility services at the Service Address shown on this application, and that this application for medical equipment exemption is valid and not an attempt to delay or avoid just payment for services provided. I hereby agree to pay all billings promptly and acknowledge that this application, if approved, does not preclude BRMEMC's right to partially limit utility services at the service address to pursue legal collection avenues for the recovery of unpaid billings, or to disconnect service under BRMEMC's Policies and Procedures. I hereby acknowledge that if BRMEMC approves a medical equipment exemption, disconnection of electric service will be postponed for 30 days from the original scheduled disconnection date to allow time for me to make payment or alternative shelter arrangements. I hereby acknowledge that this postponement will only be granted twice in a twelve month period. I hereby acknowledge that BRMEMC will disconnect utility services after providing notice in advance of disconnection for nonpayment in accordance with BRMEMC's policies and procedures. I agree to pay BRMEMC for costs and expenses of all acts taken for collection of unpaid billings.

Customer's Signature	Date
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PATIENT

I hereby attest that I am a full-time, permanent resident at the BRMEMC Service Address shown on this application and that my medical condition is such that the complete termination of BRMEMC electric service would seriously endanger my health. In consideration of BRMEMC's approval of this application, I acknowledge BRMEMC's right to limit the delivery of BRMEMC services to this service address during any and all periods of non-payment, up to and including complete disconnection of service after providing advance notice in accordance with BRMEMC Policies and Procedures. I agree to hold BRMEMC harmless from any damages relating to any complete termination that may occur incidentally as a result of system failure, or due to nonpayment by the BRMEMC service customer. In the event termination does occur, I agree to promptly notify and cooperate with BRMEMC so service may be restored as soon as possible. I release BRMEMC from all liability, claims, damages for property damage, injury or death, or expenses that may result from any complete termination which may occur incidentally as a result of system failure or due to nonpayment.

Patient's Signature	Date
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MEDICAL AUTHORITY

I hereby attest that I am a _____ licensed physician / _____ professionally certified health services official, that I have personally examined the above named patient, and that I have confirmed that complete termination of BRMEMC electric service would seriously endanger the patient's health for the following reason (describe nature of illness and effect on health of the complete absence of utility services):

Nature of Illness:

How will the lack of electricity affect this customer:

How long has condition existed:

Length of time condition expected to last:

Type of medical equipment:

Does equipment have battery back-up:

Does equipment function on 110 volt service:

Medical Authority's Signature	Address	Phone #
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Print Name	Title	Date
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4/2015	FOR BRMEMC USE ONLY	DATE	NAME
	Application Received		
	Exemption Approved		

THIS EXEMPTION WILL EXPIRE MIDNIGHT: