Critical Account Registry Form

Name_____

SVEC Acct. #_____ Telephone #_____

Address_____

Type of Life-Support Equipment_____

Standby generator available? [__] Yes [__] No

Maximum time you can safely be without electricity _____ hours.

Could individual be moved to hospital or other location with electricity? [__] Yes [__] No

Your signature_____

(Attach physician's executed certification)

****Please Do Not Mail With Bill Payment****