MOON LAKE MLEA ELECTRIC ASSOCIATION

Life Support Equipment Verification

Please provide ALL the requested information.
Moon Lake Electric may require that information on this form be updated annually.
Please contact Moon Lake Electric with at 435-722-5400 with any questions.
Completed applications can be returned to our offices or via the one of the following:

EMAIL:
accountinfo@mleainc.com

MAIL:
PO Box 278
Roosevelt, UT 84066

FAX:
435-722-5466

Account Holder Information

Account Holder Name: _____ **Account #:** _____

Service Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email Address: _____ **Primary Phone:** _____ **Secondary Phone:** _____

Patient Information

Patient Last Name: _____ **First:** _____ **Middle:** _____

Birth Date: _____ **Relationship to Account Holder:** _____

Account Holder Certification

As the Account Holder, I certify that, pursuant to Utah Administrative Code R746-200-7D, the listed patient is a full-time member of the household, and is using an iron lung, respirator, dialysis machine, or other life-supporting equipment, as described in the "Physician Information" section below. I also understand that I continue to be responsible for the electrical service at the service address listed above.

Account Holder Signature: _____ **Date:** _____

Physician Information

This section must be filled out by the patient's licensed physician.

Physician Last Name: _____ **State License #:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Phone: _____ **Secondary Phone:** _____ **Fax:** _____

Please Describe the Patient's Health Condition, as well as any necessary life-supporting equipment:

Is electricity necessary to run this equipment? _____ **Estimated Duration of Equipment Use:** _____

Physician Certification

This section must be signed by the patient's licensed physician.

As the Patient's Physician, I certify that, pursuant to Utah Administrative Code R746-200-7D, the use of an iron lung, respirator, dialysis machine, or other life-supporting equipment, as described above, is required for the patient listed in the "Patient Information" section above.

Physician Signature: _____ **Date:** _____

For Office Use Only

Processed By: _____ **Date Processed:** _____ **Date Pulled:** _____