OXFORD UTILITIES

MEDICAL EQUIPMENT EXEMPTION

OU Service Address:	**Account Number:**	
Customer's Name	**Mailing Address**	**Phone Number:**
Patient's Name Phone#		

CUSTOMER

I hereby attest that I am responsible for payment of the Oxford Utilities (OU) bill for 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 OU'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 OU's Policies and Procedures. If OU approves a medical equipment exemption and I fail to enter into a written time-payment agreement within 30 days of the application approval, or to abide by its terms, OU will disconnect service after providing notice in advance of disconnection for nonpayment in accordance with OU's policies and procedures. I agree to pay OU for costs and expenses of all acts taken for collection of unpaid billings.

Customer's Signature: **Date:**

PATIENT

I hereby attest that I am a full-time, permanent resident at the OU Service Address shown on this application and that my medical condition is such that the complete termination of OU utility services would seriously endanger my health. In consideration of OU's approval of this application, I acknowledge OU's right to limit the delivery of OU 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 OU Policies and Procedures. I agree to hold OU 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 OU service customer. In the event termination does occur, I agree to promptly notify and cooperate with OU so service may be restored as soon as possible. I release OU 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:**

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 OU utility services 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 #**
Print Name	**Title**	**Date**

3/2015

FOR OU USE ONLY	DATE	NAME
Application Received		
Exemption Approved		