

Medical dependency form



This form is to be completed and signed by your medical practitioner to confirm that you have a serious medical condition and are dependent on electricity for critical medical support. You will then be placed on Contact Energy's Medical Dependency Register. Please note that we are unable to guarantee a 24-hour continuous supply of energy. Please ensure you have a back-up plan in place in case of a power outage.

If you have any questions about this form please call our Customer Service team on **0800 80 9000**.

Section one (to be completed by patient or patient's parent/guardian or authorised representative)

Account holder details

Energy account name(s) *The name(s) on your Contact Energy bill.*

> Title > First name(s) > Last name

Account number *Your account number is on your bill.*

Patient contact details

Patient name

> Title > First name(s) > Last name

Daytime phone

> Area code > Number

Mobile phone

> Network code > Number

Work phone

> Area code > Number

Email address

Patient home address

> Number > Street

> Suburb > Town or city

> Post code

I confirm that Contact Energy is authorised to discuss the following with the registered medical practitioner listed below to confirm the need for electricity to remain connected at the medically dependent person's address, and to re-confirm that need every 12 months:

- 1 Details of my medical condition, or
- 2 Details of the medical condition of the medically dependent person referred to above, and I confirm that I am authorised to act on behalf of that person.

Information may also be passed on to the relevant electricity lines company.

Signature of patient

or patient's parent/guardian or authorised representative

Section two (to be completed by medical practitioner)

Medical practitioner details

Medical practitioner name

Designation *For example, General Practitioner or Specialist.*

Medical practice centre *For example, health centre or surgery.*

Daytime phone

> Area code > Number

Mobile phone

> Network code > Number

Email address

Please turn over to complete

Section two continued (to be completed by medical practitioner)

Medical details

Description of medical condition

[Four horizontal grey bars for text input]

Type of equipment requiring a continuous supply of electricity

[Four horizontal grey bars for text input]

Duration for which equipment will be required

Permanently require equipment
 Temporarily require equipment > Required until
> Day > Month > Year

Declaration by medical practitioner

I state that
> Medical practitioner > Patient

has a serious medical condition and needs electricity for medical reasons.

Signature of medical practitioner Date
> Day > Month > Year

Medical practitioner's stamp *Important: This form will not be valid unless a medical practitioner's stamp is provided in the box below.*

[Large empty rectangular box with a red border for the medical practitioner's stamp]

Please post the completed form back to us in the FreePost envelope if you have one, or post to:
Contact Energy Limited, PO Box 624, Wellington 6140.

Alternatively, you can fax it to us on 0800 508 101.