CLARKSVILLE DEPARTMENT OF ELECTRICITY
APPLICATION FOR MEDICAL EMERGENCY CERTIFICATION

CDE USE ONLY	DATE	NAME
Application Received		
Exemption Approved		

Please Print

CDE Account Number		CDE Billing Address
Customer Name	Service Address	Phone Number
Patient Name		Phone Number

CUSTOMER

I hereby attest that I am responsible for payment of the CDE billing of utility services at the service address shown on this application, and that this application for medical emergency certification 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 CDE's right to partially limit utility services at the service address to pursue legal collection activities necessary for the recovery of unpaid billings, or to disconnect service under CDE's policies. CDE will disconnect service after providing notice in advance of disconnection for nonpayment in accordance with CDE policies.

Customer Signature Date

PATIENT

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

MEDICAL AUTHORIZATION

I hereby attest that I am a ☐ licensed physician / ☐ professionally certified health services official, that I have personally examined the above Patient, and that I have confirmed that complete termination of CDE electric service would seriously endanger the patient's health.

☐ **This Patient suffers form a hazardous medical condition and termination of electric service would be especially dangerous or life-threatening.**

☐ **This Patient uses medical or life-supporting equipment and termination of electric service would make operation of this equipment impossible or impractical.**

I have advised my patient that disclosure of the requested information may be subject to redisclosure by the recipient and no longer protected by HIPAA rules & regulations.

Medical Authority's Signature	Business Address	Phone Number
Print Name	Title	Date

This certification will expire 1 year from date of Approval. It is the responsibility of the Customer/Patient to renew this certification if conditions extend beyond 1 year.

Mail: **CDE Operations Dept.**
PO Box 31509
Clarksville, TN 37040
Email: ***criticalaccounts@clarksvillede.com***

Fax: **931.648.9466**

For assistance call:
931.905.7203