Medical Preparedness Program

APPLICATION FOR ENROLLMENT

Thank you for your interest in the SRP Medical Preparedness Program. To complete the approval process, follow the steps below:

1. Fill out Part I of this form completely.
2. Have your doctor fill out Part II of this form and write a prescription slip for all required, SRP-approved, FDA Class III, electricity dependent medical devices.
3. Return the completed application and prescription slip to SRP as soon as possible. You can mail back your paperwork using the envelope we've provided or email pictures of your paperwork to **crc_medical@srpnet.com**. You can also fax your paperwork to **(602) 629-7909**. Incomplete applications will not be processed.

PART I – To be completed by customer

NAME AS IT APPEARS ON YOUR SRP BILL

SRP ACCOUNT NUMBER

SRP SERVICE ADDRESS

EMAIL ADDRESS

PHONE NUMBER

I give my physician permission to release pertinent medical information to SRP. I understand that:

- If I am enrolled in the program, my bill payment terms won't change. If I don't pay my electric bill or reach out to SRP for support, it's possible that my service may be disconnected.
- If I am an M-Power customer and I am eligible for the program, I will be switched to the residential Basic Price Plan.
- SRP strongly recommends having an uninterruptible power source (such as a portable generator, battery backup, etc.) that would operate mechanical equipment in the event of power loss.
- SRP may ask to verify that qualifying medical equipment is in use at any time.

SIGNATURE

DATE

Have questions? We're here to help. Call **(602) 236-3000** Monday through Friday, 8 a.m.–5 p.m.

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PART II – To be completed by prescribing physician who is licensed to practice medicine in the state of Arizona.

Fill out this form completely, then provide a prescription slip for all SRP-approved, FDA Class III, electricity dependent medical devices that the patient uses in their home. The slip should include the type of eligible equipment, today's date and your signature.

____ - ____ - _____

SRP ACCOUNT NUMBER

PATIENT'S NAME

PATIENT'S DOB (REQUIRED)

Is the equipment located in the home? ☐ Yes ☐ No

Is the equipment essential to sustaining life and SRP-approved? ☐ Yes ☐ No

Such equipment is defined as "medical equipment where a discontinuance of service from the equipment for a period longer than four hours could be especially dangerous to an individual's health."

Which of the following types of SRP-approved, FDA Class III, electricity dependent medical devices does the patient require? Select all that apply.

☐ Hemodialysis or peritoneal dialysis machine
☐ Ventilator
☐ Infant apnea monitor
☐ Feeding or infusion pump
☐ Suction machine
☐ Oxygen concentrator
☐ Left ventricular assist device

I certify that the equipment indicated above is required for the patient.

PRINTED PHYSICIAN NAME (REQUIRED)

PHYSICIAN SIGNATURE (REQUIRED)

DATE

( )

PHYSICIAN PHONE NUMBER

( )

PHYSICIAN FAX NUMBER

PATIENT OR LEGAL GUARDIAN SIGNATURE*

*Required if different from SRP customer. Parent or legal guardian must sign if the patient is under the age of 18.