

MEDICAL DEPENDENCY FORM

Date _____

This form must be completed by a registered Medical Practitioner confirming the patient has a serious medical condition and is reliant on electricity of medical support.

CUSTOMER TO COMPLETE

KCE Account Name:		
KCE Account Number:		

PATIENT OR NEXT OF KIN ON BEHALF OF FAMILY MEMBER TO COMPLETE

Patient Name:	
Date Of Birth:	
Residential Address:	
Contact Details	HOME:
	MOBILE:
	WORK:
	E-MAIL:

I confirm that King Country Energy LTD is Authorised to discuss

1. Details of my medical condition; and if applicable
2. Details of the medical condition of the medically dependent person referred to above (and I confirm that this person has authorised this) with the registered medical practitioner listed above and/or the practitioner who has provide the medical certificate to confirm the need for power to remain connected at my address. Information may also be passed onto my network company.
3. Details of my medical and account balance may be disclosed to a third party such as Work & Income and/or a budgeting agency in order to resolve as unpaid balance on my account.

DOCTOR TO COMPLETE

Name of Doctor	
Designation [eg: GP or Specialist]	Registration No.
Contact Details	MOBILE:
	WORK:
	E-MAIL:
Patients Medical Condition	
Equipment Type Requiring Electricity	
Duration of Equipment Requirements	Permanently Requires Equipment
Delete Option which is NOT applicable	Equipment required until below date

I, _____ [Medical Practitioner] state that _____ [Patient] has a serious medical condition and requires Electricity for medical reasons

Signed [Medical Practitioner]: _____ Date: _____