

**MINNESOTA – CITY OF KASSON**  
**CRITICAL LIFE-SUSTAINING MEDICAL EQUIPMENT FORM**

*Subd. 5 Medically necessary equipment. A utility shall reconnect or continue service to a customer's residence where a medical emergency exists or where medical equipment requiring electricity necessary to sustain life is in use, provided that the utility receives from a medical doctor written certification, or initial certification by telephone and written certification with five business days, that failure to reconnect or continue service will impair or threaten the health or safety of a resident of the customer's household. **The customer must enter into a payment agreement.***

**I. CUSTOMER CERTIFICATION: (to be completed by customer)**

Customer Name: \_\_\_\_\_ Account #: \_\_\_\_\_  
Customer Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Resident(s) requiring life –sustaining medical equipment: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Customer: \_\_\_\_\_

**II. RELEASE: (to be completed by Resident requiring life-sustaining equipment or his/her legal guardian)**

I \_\_\_\_\_ (circle one: resident or legal guardian) hereby grant my consent to the below-named licensed physician to release to the City of Kasson such information as noted below, plus any supplemental information regarding critical medical equipment used at the residence.

Signature of Resident or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**III. MEDICAL VERIFICATION: (to be completed and signed by a licensed physician)**

The above named customer is currently using one of the following **LIFE-SUSTAINING** medical devices.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Ventilator      | <input type="checkbox"/> Sleep Apnea         | <input type="checkbox"/> Heart Monitor                     |
| <input type="checkbox"/> Infusion pump   | <input type="checkbox"/> Feeding Pump        | <input type="checkbox"/> *Other – Critical Life Sustaining |
| <input type="checkbox"/> Kidney Dialysis | <input type="checkbox"/> Oxygen Concentrator | <input type="checkbox"/> Other – Not Life Sustaining       |
| <input type="checkbox"/> Respirator      | <input type="checkbox"/> Suction Machine     |  |

\*If you have selected Other – Critical Life Sustaining, the City of Kasson requires an explanation of the Life Support equipment that is used at this residence: \_\_\_\_\_

I certify that the termination of electricity would disrupt the use of **LIFE SUPPORT EQUIPMENT** and would create a medical emergency for \_\_\_\_\_ who is a permanent resident at: \_\_\_\_\_.

Physician Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Please fax or mail completed form to:  
City of Kasson  
Attn: Cassie  
401 Fifth Street SE  
Kasson, MN 55944  
Fax: 507.634.4737