Medical Dependency Form

This form is to be completed by the account holder, or the medically dependent person or their authorised representative (if different from the account holder), and signed by the medical practitioner to confirm that there is a serious medical condition and a dependency on electricity for critical medical support at your property. Please return the completed form to Genesis Energy and you will then be placed on Genesis 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 queries about this form please call us on **0800 400 460.**

SECTION 1 (To be completed by medically dependent person, their parent or guardian or authorised representative)

Account holder's details

Customer Number ______________________________

Customer Name ______________________________

Contact Phone Number(s) **Home (0)** ____________ **Work (0)** ____________ **Mobile (0)** ____________

Medically dependent person to complete

Medically Dependent Person's Name ______________________________

Date of Birth ______ / ______ / ______

Contact Phone Number(s) **Home (0)** ____________ **Work (0)** ____________ **Mobile (0)** ____________

No. and Street Address ______________________________

Suburb/Town ____________ **City/Province** ____________ **Postcode** ____________

Consent by medically dependent person or their representative

I confirm that my medical practitioner is authorised to discuss the details of my medical condition, or (if applicable) of the medically dependent person referred to above and I confirm that I am authorised to act on behalf of that person.

Delete as applicable:

As the recipient of this medical equipment and a medically dependent person, I consent to the information on this form and information on the future status of my dependency on the medical equipment, to be shared between the health practitioner(s), electricity retailer(s) and/or the electricity account holder for the domestic residence where I will be residing, for the purpose of ensuring that the electricity retailer is informed of my medical dependency on electrical equipment and my status as a medically dependent person.

As the authorised representative of a medically dependent person, I consent to the information on this form and information on the future status of their dependency on the medical equipment, to be shared between the health practitioner(s), electricity retailer(s) and/or the electricity account holder for the domestic residence where the medically dependent person will be residing, for the purpose of ensuring that the electricity retailer is informed of their medical dependency on electrical equipment and their status as a medically dependent person.

Signature (Medically Dependent Person/Parent/Guardian/Authorised person) ______________________________

Print name ______________________________ **Date** ______ / ______ / ______

Relationship to Medically Dependent Person (if applicable) ______________________________

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Medical Dependency Form

SECTION 2 (To be completed by medical practitioner)

Medical practitioner details

Medical Practitioner's Name ______________________________

Designation (for example, GP or Specialist) ______________________________

Medical Practice Centre (for example, surgery or health centre) ______________________________

Contact Telephone Numbers ______________________________

Email Address ______________________________

SECTION 3 (Confirmation that electricity **is/is not** required)

This section is to be completed by a registered doctor. Please take into consideration the definition below of medical dependency as per the Electricity Authority's Guideline on arrangements to assist medically dependent customers.

- A Medical Dependent Customer is a person who is dependent on mains electricity for critical medical support, and loss of electricity may result in loss of life or serious harm.
- Critical Electrical Medical Equipment (CEME) is any equipment supplied or prescribed by a District Health Board, private hospital or General Practitioner, which requires mains electricity to operate and where loss of that electricity could result in an immediate threat to life or cause serious harm, for example, dialysis machine and oxygen concentrators.

Declaration by Medical Practitioner

I certify that ______________________ (person named on this form) has a serious medical condition and is dependent on a continuous supply of power for Critical Electrical Medical Equipment, at the address mentioned at the top of this form.

Type of equipment requiring a Continuous Supply of Electricity ______________________________

☐ **Requires equipment long term** ☐ **Temporarily requires equipment until** ______ / ______ / ______ **(specify date)**

OR

At the present time, I DO NOT consider that ______________________ (person named on this form) is dependent on a continued supply of electricity for Critical Medical Support.

If you consider the person to be vulnerable for reasons of Health, Age, Disability or Low Income, please complete the section below

I consider the person to be VULNERABLE for reasons of ☐ **Health** ☐ **Disability** ☐ **Age** ☐ **Low income**

Signature of Medical Practitioner ______________________________ **Date** ______ / ______ / ______

Official Stamp

Customer Number

Please return this by mail to:
Genesis Energy, Private Bag 3131,
Waikato Mail Centre, Hamilton 3240

Email to: info@genesisenergy.co.nz

Or fax to: 0800 110 999

Customer Declaration

There is **no longer** a medical dependency status required for the customer or any person living at this property.

Customer Name ______________________________

Customer Number ______________________________

I have read and considered all the information I have received, regarding the requirements for electricity for critical medical support.

I wish to advise that I no longer regard myself or anyone in my household medically dependent on a continued supply of electricity for critical medical support.

I wish the medically dependent status to be removed from my energy account.

Name ______________________________

No. and Street Address ______________________________

Suburb/Town ______________ **City/Province** ______________ **Postcode** __________

Signature ______________________________ **Date** ______ / ______ / ______