

# BRODHEAD WATER & LIGHT

## CRITICAL NEEDS CUSTOMER FORM

Office 608-897-2505 Fax 608-897-2726

Date \_\_\_\_\_

Customer's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Account Number \_\_\_\_\_

Type of Electrical Medical  
Equipment \_\_\_\_\_

Frequency of Use \_\_\_\_\_

Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_

Equipment Supplier \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Where will you go if there is a power outage of 2 hours or less?  
\_\_\_\_\_

Where will you go if there is a power outage of more than 2 hours?  
\_\_\_\_\_

### Emergency Contact Person

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Cell \_\_\_\_\_

Best time to reach them \_\_\_\_\_

Other Information \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_