COLTON PUBLIC UTILITIES
APPLICATION FORM- LIFE SUPPORT/MEDICAL BASELINE
ADDENDUM TO RESOLUTION NO. 4213 EXHIBIT A

_____	_____
Customer Name	Customer Utility Account Number
_____	( )_____
Service Address	Home Phone Number
_____	( )_____
City Zip Code	Business Phone Number

_____
Name of Person (s) with medical condition or using life support device

_____
NAME OF PHYSICIAN OR OSTEOPATH LICENSED TO PRACTICE MEDICINE IN STATE OF CALIFORNIA (Photocopy prescription or letter by physician detailing type of regularly required life support device and utilization requirements). **ATTACH COPY TO THIS FORM.**

_____
Name of person or business supplying life support device

_____	_____
Address	Phone Number

_____
City State Zip Code

Life support device to be/was installed_____

Equipment_____Kw Rating_____Hrs. of daily use

NOTE TO THE APPLICANT:
A REPRESENTATIVE FROM COLTON PUBLIC UTILITIES MAY CALL FOR AN APPOINTMENT TO VERIFY EQUIPMENT INSTALLATION AND kW RATING PRIOR TO THE LIFE SUPPORT RATE BEING APPLIED TO THE ACCOUNT**.**

THE DISCOUNT ON YOUR UTILITY BILL WILL OCCUR WITHIN 30 DAYS OF VERIFICATION.

CITY USE ONLY
DATE OF VERIFICATION_____

_____kW RATING X _____HRS. OF DAILY USE
_____kW PER DAY X 30 DAYS_____ kWH EXTENSION IN LOW BLOCK RATE

_____
DEPARTMENT REPRESENTATIVE SIGNATURE