



Alliance Metering Solutions

# CRITICAL CARE CUSTOMER NOTIFICATION REGISTRATION FORM

526 Country Squire Rd  
Waterloo ON,  
N2J 4G8  
Tel: 519-888-5593  
info@alliancemetering.com

## PERSONAL INFORMATION

DATE: \_\_\_\_\_ ACCOUNT NUMBER: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_  
First Name Middle Initial Last Name

SERVICE ADDRESS: \_\_\_\_\_  
Street City Province Postal Code

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

ALTERNATE CONTACT NAME \_\_\_\_\_  
First Name Middle Initial Last Name

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

I, \_\_\_\_\_, consent to the release of the following information to Alliance Metering Solutions Inc., for the purpose of enabling me to be enrolled in its critical customer notification program. I hereby authorize and direct my physician to complete this form for this purpose.

## TO BE COMPLETED BY A LICENSED PHYSICIAN

PHYSICIAN NAME: \_\_\_\_\_ PHYSICIAN PHONE: \_\_\_\_\_

PHYSICIAN ADDRESS: \_\_\_\_\_  
Street Address City Province Postal Code

TYPE OF MEDICAL EQUIPMENT: \_\_\_\_\_

DOES EQUIPMENT HAVE BATTERY BACKUP  YES  NO IF YES, FOR HOW LONG? \_\_\_\_\_

I CERTIFY THAT THE PERSON LISTED ABOVE USES LIFE SUPPORT EQUIPMENT REQUIRING AN ELECTRICAL CONNECTION

PHYSICIAN SIGNATURE \_\_\_\_\_

## TO BE COMPLETED BY CUSTOMER

I ACCEPT THE CONDITIONS AND CERTIFY THAT THE DETAILS PROVIDED ARE ACCURATE

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

*\*Customers who require an uninterrupted source of power for medical related equipment must provide their own back up equipment for these purposes. Although Alliance Metering Solutions Inc. does not guarantee the availability of power or the length of any power interruption, we will make every effort to mitigate length of interruption and where practical will provide advanced notice.*

Please forward by mail, or email to:

Alliance Metering Solutions Inc.,  
526 Country Squire Road  
Waterloo, ON  
N2J 4G8  
info@alliancemetering.com