Critical Customer Notification Registration Form

Personal Information

Date: _____ Account Number: _____

Patient's Name: _____

Service Address

Street: _____ City/Town: _____ Province: _____

Postal Code: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

I _____ consent to the release of the following information to Enova Power for the purposes of enabling me to be enrolled in its critical customer notification program. I hereby authorize and direct my physician to complete this form for that purpose.

To be completed by a licensed physician:

Physician Name: _____ Physician Phone: _____

Physician Address:

Street: _____ City/Town: _____ Province: _____

Postal Code: _____

Type of Medical Equipment: _____

Does Equipment Have Battery Backup: ☐ Yes ☐ No. If yes, for how long? _____

☐ I certify that the person above uses life support equipment requiring an electrical connection.

Physician's Signature: _____

To be completed by the customer

☐ I accept 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 Enova Power 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 email, or mail to; Enova Power, 301 Victoria Street South, Kitchener ON, 42G 4L2, or customercare@enova.com.