



**MEDICAL FORM** (complete and **attach required physician documentation**)

Name of Account Holder: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Are You or a Member of your Household Presently on a Life-Support System? (Y/N) \_\_\_\_\_

Name and Relationship: \_\_\_\_\_

Telephone Number: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email: \_\_\_\_\_

Kind of Life-Support System: \_\_\_\_\_

Any Other Information That Might Be Helpful in Case of Emergency: \_\_\_\_\_

\_\_\_\_\_

**REQUIREMENTS FORM** (initial)

\_\_\_\_\_ Jones-Onslow EMC will be notified immediately concerning any changes in the medical status of my account.

\_\_\_\_\_ I understand my account is subject to Jones-Onslow EMC's Service Rules and Regulations regarding disconnections of service for past due accounts.

\_\_\_\_\_ I understand Jones-Onslow EMC reserves the right to remove the medical status from any account that defaults on making monthly payments or does not provide the required yearly renewal medical documentation.

\_\_\_\_\_ I understand Jones-Onslow EMC will notify me whenever possible regarding outages. This notification does not guarantee continuous and uninterrupted service.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Jones-Onslow EMC  
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