Application to be added to medical dependency register.

PLEASE NOTE:
This form is to be completed by the Orcon Homeline Account Holder or their Representative. It requires proof to be attached from a Medical Practitioner confirming that someone who lives at the address is dependent on telephone access for critical medical support. Once the completed form is received together with a medical certificate and assuming it is deemed by us to fit our criteria of when a customer should be placed on the Medical Dependency register the person will be placed on the register for 1 year maximum.

Please email the completed form and medical certificate to customer.care@orcon.net.nz or post to Orcon, P.O. Box 302362 North Harbour, Auckland.

To be filled in by the person who is dependent on a home telephone service or their representative.

Homeline account number: .....

Account holder first name: .....

Account holder surname: .....

Residential address: .....

Homeline phone number (required for medical purposes): .....

Contact phone number (If different from above): .....

Mobile number (if you don't provide a mobile number we will be limited in our ability able to make contact to warn of any changes to service): .....

Is the account holder is medically dependent or is it someone else in the household: Is the account holder medically dependent? ..... **YES / NO** (PLEASE CIRCLE)

Medical dependent first name: .....

Medical dependent surname: .....

Please provide an alternative contact not living at the same address: .....

.....

.....

Alternative contact person name: .....

Alternative contact relationship to you: .....

To be filled in by your medical practitioner: .....

Designation (I.e. GP, Specialist etc..): .....

Medical practitioner first name: .....

Medical practitioner surname: .....

Business address: .....

Phone number: .....

Mobile number: .....

After hour's number: .....

Official stamp of professional registration: .....

Certificate of membership number: .....

Name of patient requiring continued access to telephone service: .....

.....

Confirm patient has a condition which requires

continuous access to a telephone service: ..... **YES / NO** (PLEASE CIRCLE)

I have attached a medical certificate signed by a

Medical Practitioner to support this: ..... **YES / NO** (PLEASE CIRCLE)

SUBMITTING YOUR APPLICATION MEANS YOU ACKNOWLEDGE THE FOLLOWING:

I understand that Orcon cannot guarantee continuous or fault free services.I have thought about what I would do in case of an unexpected outage. I understand that Orcon will not always be able to inform me in advance if services will be unavailable. I understand that Orcon strongly recommends that customers who have a medical dependency on their phone line have a mobile phone as well as a Home phone. I understand that a cordless phone may rely on mains power and may not work if there is a power outage even if the services I receive from Orcon still work.
I have provided the contact details for an alternative contact who lives nearby and who has agreed to act as my alternative contact. I understand that Orcon may contact my alternative contact about me and my services as required for the purposes of the register.
I understand that being on the Medical Dependency Register does not exclude me from collection action if my account is overdue. I confirm that all of the information I have provided on this form is correct. I confirm that I fulfil the eligibility criteria for Medical Dependency Registration, as I or someone living at the nominated address has a diagnosed life-threatening medical condition that leaves me/someone living at this address at a high risk of a rapid deterioration to a life-threatening situation and where access to a telephone would assist to remedy the lifethreatening situation. I acknowledge that Orcon has the right to refuse my application if I do not meet the eligibility criteria (which may be subject to review). I consent to Orcon collecting the information provided with this form and to use this information for the purposes of:

- assessing the patient's eligibility to be included on that Orcon Medical Dependency Register;
- providing, administering and managing such register; and
- Providing, administering and managing the services provided to the above-mentioned customer

Please read and sign:

I have read and understood the terms and conditions outlined above and understand fully the provisions of being included on the Medical Dependency Register.

Signed: ..... Date:.....