Clear River
Electric & Water District

Dear Customer:

As hurricane season approaches, Clear River Electric & Water District (CREW) is updating its "Priority List". This list contains customers who are **dependent upon electricity to power life support equipment**. We update this list annually.

If you have special requirements that are life threatening, please have your licensed physician fill out the applicable information and return to CREW at PO Box 107 Pascoag, RI 02859. Although you will be given a high priority designation, CREW can not guarantee the continuance of electricity in an emergency situation, nor can CREW guarantee that your service will be the first restored after an outage.

If you are dependent upon electricity to power life support equipment, please incorporate back up generation in your family's plan. In the event you do not have back up generation, please plan to evacuate your family to a community shelter that can provide you with electricity.

Last month, CREW sent all its residential customers an "Emergency Checklist". This list provides a basis for your emergency plan. If you did not receive a copy of the checklist, please call our office and we will send you one.

In the case of a prolonged outage , you can get status updates the following ways:

- Call our office at 401-568-6222 and select Option 2.
- Visit our outage map at https://crewri.org/outages-safety/outage-map
- Login to your SmartHub account online or on the app.
- Follow us on Facebook at https://www.facebook.com/ClearRiverElectricandWater

Please consider joining the RI Special Needs Emergency Registry also, by registering online at https://kidsnet.health.ri.gov/emregistry/form.html

If you have any questions, please call the District office at (401) 568-6222.

Sincerely,
Clear River Electric & Water District Staff

***Please have your licensed physician fill out the applicable information below.**

Priority Customer Registration Form

Name of Priority Customer: _____ Date of Birth: _____

Name on Electric Bill: _____ Electric Account No: _____

Service Address: _____ Apartment/Unit: _____

Best Contact Phone Number: _____Email Address: _____

Life Support Systems-Which of the following do you use?
Please circle all that apply.

- Oxygen Tank
- Respirator/Ventilator:
  if used, does it have a battery backup unit?
  Yes or No
- Electrical Pace Maker
- Medical Pump
- Oxygen Concentrator
- Home Dialysis
- Electrical Defibrillator
- Please list any other relevant conditions:

  _____
  _____

Customer Signature:

_____

Print Name: _____

Date signed: _____

Please specify the anticipated duration of the life support system: (example: 6 months, 1 year, life time)

_____
_____
_____

Print Licensed Physician's Name:

_____
Physician's License Number:_____
Licensed Physician's Address:

_____
Licensed Physician's Phone Number: _____
Licensed Physician's Signature:
_____ **Date:** _____

_____
List relationship if completing on individual's behalf