MEDI + PRODUCTS

BACK-UP POWER SYSTEMS

30 NURNEY STREET, STAMFORD, CONNECTICUT 06902

203.348.2886 or 800.765.3237

RETURN FAX: 203.487.7423

IF URGENT-PLEASE INDICATE HERE

POWER REQUIREMENT EVALUATION

This is not an order. It is intended for use by our Engineering Department to ensure that you are quoted a unit that will handle your facility's needs. If you need assistance completing this questionnaire, do not hesitate to call us. **There is no charge for this service**.

Upon completion, please return by mail or fax.

Facility/Customer Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Contact:_____ Phone:_____ Fax:_____

Copy this form as necessary and use a separate form for each different procedure type.

Please list all equipment with appropriate volts/amps/watts (taken from the electrical rating plate on each appliance).
Indicate any 220-volt items. *Include estimated on-time for each piece of equipment*. Note: volts x amps = watts.

PROCEDURE NAME:_____ PROCEDURE LENGTH: HRS_____ MINS_____

EQUIPMENT TYPE (make & model #)	VOLTS	AMPS	WATTS	RUN-TIME USE

Do you currently have any type of emergency power system? □ **Yes** □ **No**

Do you wish ceiling-mounted surgery lights to be powered? □ **Yes** □ **No**

Do you own an auxiliary portable surgery lamp? □ **Yes** □ **No**

Are you interested in purchasing one? □ **Yes** □ **No**

Is there any other equipment needed?_____

Are you seeking accreditation? □ **Yes** □ **No** **If so, with which association?**_____

HOW DID YOU HEAR ABOUT THE *REASSURANCE*™?

Trade Journal:_____ Issue:_____

Sales Rep.: _____ Referral (name):_____

Your signature: _____ Title:_____ Date:_____

Best time to contact:_____ Day of the week:_____

Thank you for taking the time to complete this important form. Our Engineering Department will review and confirm your facility's emergency power requirements and will be in contact with you shortly.