LIFE SUPPORT EQUIPMENT CERTIFICATION

People. Power. Possibilities. Central Hudson A FORTIS COMPANY

Please print or type

LSA No. _____

SECTION I - Individual Using Medical Equipment

Name of Person with Equipment: _____ Birthdate: _____

Address: _____ Home Phone No: _____

Cell Phone No: _____ Email Address: _____

Emergency Contact Name: _____ Home Phone No: _____

Cell Phone No: _____ Email Address: _____

SECTION II - Customer Information & Statement

Is your residence located in:

- ☐ Private Home – Homeowner's Name: _____
- ☐ Complex/Facility – Name: _____

Central Hudson Customer Name: _____ Account No.: _____

Home Phone No: _____ Cell Phone No: _____ Email: _____

I, the undersigned, understand that while on the Life Support Program, I remain solely responsible for payment of utility service and shall make reasonable efforts to pay charges for such service.

Customer Signature: _____ Date: _____

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SECTION III - Medical Equipment Information

- ☐ Tank-Type Respirator (Iron Lung)
- ☐ Cuirass-Type (Chest) Respirator
- ☐ Electrically Operated Respirator
  (Operated 12+ hours per day)
- ☐ APNEA Monitor (**Infants Only**)
- ☐ Other Type of Life Support Device
  *(please describe)*_____
- ☐ Rocking Bed
- ☐ Suction Machine (Pump)
- ☐ Hemodialysis Equipment (Kidney Machine)
- ☐ Intermittent Positive Pressure Respirator
- ☐ Continuous Ambulatory Peritoneal Dialysis

Frequency of Use:_____ Times Per Week:_____ Hours Per Day:_____

Name of Equipment Supplier:_____ Telephone No:_____

Does customer have back-up equipment in case of power outage? ☐ Yes ☐ No

SECTION IV - Physician's Statement

In accordance with the definition of a life support device and the information listed above as proof of use of such a device, I certify that the above-named individual does require an electrically operated device to sustain his/her life. This equipment requires uninterrupted electrical power for extended periods of time.

Physician: _____ Physician's License Number:_____

Telephone No.: _____

Address: _____

Signature: _____ Date: _____

SECTION V - To Be Completed If Equipment Is No Longer Required

I hereby certify that life support equipment is no longer in use and the protection afforded by Central Hudson's Life Support Program are no longer required.

Name:_____

Signature:_____ Date: _____