

# LIFE SUPPORT APPARATUS CERTIFICATION

*Please print or type*

LSA No. \_\_\_\_\_

## SECTION I - Individual Using Medical Equipment

Name of person using life support device: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Telephone No: \_\_\_\_\_

## SECTION II - Customer Information & Statement

Is your residence located in:

Private Home – Homeowner’s Name: \_\_\_\_\_

Complex/Facility – Name: \_\_\_\_\_

Central Hudson Customer Name: \_\_\_\_\_ Account No.: \_\_\_\_\_

*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: \_\_\_\_\_

## 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: \_\_\_\_\_

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: \_\_\_\_\_