

LIFE SUPPORT APPARATUS CERTIFICATION

Please print or type

SECTION I

Name of person using life support device: _____ Age: _____

Address: _____ Telephone No: _____

Signature: _____ Date: _____

Person to contact in case of emergency: _____ Telephone No.: _____

SECTION II

Is your residence located in:

Private Home – Homeowner’s Name: _____

Complex/Facility – Name: _____

Central Hudson Customer Name: _____ Account No.: _____

Customer Signature: _____ Date: _____

SECTION III

Tank-Type Respirator (Iron Lung)

Cuirass-Type (Chest) Respirator

Electrically Operated Respirator

Kidney Machine) (operated 12+ hours per day)

Intermittent Positive Pressure Respirator

Continuous Ambulatory Peritoneal Dialysis

Other Type of Life Support Device

(please describe) _____

Rocking Bed

Suction Machine (Pump)

Hemodialysis Equipment

APNEA Monitor

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

Name of equipment _____ Supplier: _____

Address: _____ Telephone No: _____

Is device used during sleeping hours? Yes No
Can equipment be operated manually? Yes No
Does customer have back-up equipment in case of power outage? Yes No
Describe type of equipment _____

SECTION IV

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 by Central Hudson Gas & Electric

Map & Grid No. _____ Circuit No. _____

LSA No. _____