LIFE-SUSTAINING EQUIPMENT CERTIFICATION

Return within 10 days

CUSTOMER INFORMATION (Required information)

PSE&G Customer's Name: _____

Address: _____

PSE&G Account Number: _____ Telephone #: _____

Social Security Number: _____ (Please provide if not given on form)

TO BE COMPLETED BY PHYSICIAN (Required information)

Please type or print

Patient's name (if different from above): _____

Patient's address (if different from above): _____

Patient's telephone number (if different from above): _____

Patient's age: _____ Date last examined: _____

Type of equipment: _____

Make and Model #'s of equipment _____

How long has this individual been your patient_____

MEDICAL CONDITION(S)

ICD9CODE	DESCRIPTION	ICD9CODE	DESCRIPTION

Is there a medical condition requiring equipment? **Y / N**

Is the equipment used on an "as needed" basis?: **Y / N** Used at work/school?: **Y / N**

Is this equipment operated electrically?: **Y / N**

Can the equipment be easily moved in the event of a power outage? **Y / N**

Is an alternative power supply available? (batteries, etc.): **Y / N**

Is this considered **life support equipment?** **Y / N**

Remarks: _____

_____

_____ _____

Physician's Name (Please print or type) Physician's Address

_____ _____ _____

Physician's Signature Telephone Number Date

Please fax this form to: PSE&G at (908) 272-4405 or

Mail to: PSE&G PO Box 490, Cranford, NJ 07016 (Attention: Priority 4 Coordinator)

Revised 4/03