LIFE SUPPORT APPARATUS CERTIFICATION

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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

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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: _____