

City Light 顧客聲明書

茲證明本人使用電動生命維持設備并為下列服務地址之永久居民。

本人瞭解此聲明書並不解除本人作為顧客繳付電費之義務。本人瞭解，此聲明書所涉生命維持設備之地點如果未繳付電費，則是否延長供電服務將按個案決定，即使准予延長亦不得超過 30 天。本人還完全瞭解，如果不能繳付雙方業已同意之付款，可導致終止電力服務。

本人瞭解，此聲明書僅在本人在世期間或經證明確實存在健康危險的情況下有效，且若未經延期，有效期不得超過一年。

顧客姓名： _____

服務地址： _____

顧客簽名： _____ 日期： _____



CERTIFICATE OF MEDICAL NECESSITY

Date: _____ Seattle City Light Account Number: _____

Primary Account Holder's Name: _____

Service Address: _____

City: _____ WA Zip Code: _____

Patient Name, If not the Primary Account Holder: _____

Relation to Patient Using Life Support Equipment (Check one):

- Self Spouse/Partner Child Parent or Guardian Power of Attorney

Seattle City Light Customer's Statement:

The patient named in this certificate who uses electric-powered life support equipment is a permanent resident at the service address shown below. I understand that this certificate **does not** relieve me of the obligation to pay for electrical service. If my account becomes past due and the use of life support equipment is documented by this certificate, electrical service may be extended. **Without payment and/or pay plan, electrical service may be disconnected.**

I understand that this certificate is valid only for the length of time the medical situation is certified to exist and that it is **not valid for more than one year without renewal.**

Primary Account Holder Signature: _____ Date: ____/____/____

Statement of Patient or Their Representative Using Life Support Equipment:

The information I have provided to the licensed healthcare provider is true, and I authorize the release of the information on this certificate to Seattle City Light.

Name (print): _____

Signature: _____ Date: _____

Please list contact phone numbers and your e-mail address and check the box next to your preferred method(s) of contact:

- Primary Contact Number: _____ Cell: _____
- Emergency Contact Number: _____ Email: _____

Medical Provider's Statement (Check One):

I certify that the person listed below is my patient and uses recognized life support equipment requiring an electrical connection and that the termination of electrical service to their residence would create a life-threatening situation.

OR

I certify that the person listed below is my patient and has a health-threatening situation involving a temporary illness or condition in which loss of electrical service could result in prolonging or worsening the illness or condition.

Please complete the following:

1. **Patient's Name:** _____

2. **Patient's Address:** _____

3. **Patient uses the following life support equipment requiring an electrical connection:**

(Please check all that apply): Ventilator (Continuous Mechanical) CPAP or BIPAP device

Dispenser (Feeding Pump or Medication Dispenser) Nebulizer Machine

Dialysis (In-home Peritoneal Dialysis only) and Dialysis Provider: _____

Oxygen Concentrator (Does not include liquid or cylinder oxygen use) and Oxygen Provider: _____

Suctioning device Bed Mattress (Electric hospital bed or alternating pressure mattress)

Chair (Electric lift chair or electric wheelchair, rechargeable)

Heating/Cooling (Patient is vulnerable to extreme temperatures due to serious long-term medical condition and patient's health will be significantly endangered by the termination of electrical service for heating/cooling).

HOSPICE In-Home Care Other Life-Support Equipment Requiring Electricity (**Type**): _____

4. **Patient's use of life support equipment is expected to be:** (Check one)

Short-term (Less than 60 days)

Long-term (More than 60 days)

5. **For temporary health-threatening situation NOT involving life support equipment,** explain how the health of the patient will be significantly endangered by the loss of electrical service:

Signature of Licensed Healthcare Provider: _____

Name (Please Print): _____

Date: _____

Healthcare Provider's I.D. Number: _____

Phone: _____

Provider's Name & Address: _____

Healthcare Provider -PLEASE SUBMIT COMPLETED CERTIFICATE BY THESE FOLLOWING METHODS:

FAX to LIFESUPPORT Program (206) 287-5074 OR EMAIL: SCL_LifeSupport_Prg@Seattle.Gov

MAIL: **ATTEN: SCL LIFESUPPORT PRG;** 700 5th Ave Ste# 2842; Seattle, WA 98124-4023