

### **Giấy Xác Nhận của Khách Hàng City Light**

Người có tên trong Giấy Chứng Nhận này, người sử dụng máy móc trợ sinh bằng điện, là cư dân thường trú tại địa chỉ nhận dịch vụ dưới đây.

Tôi hiểu rằng Giấy Chứng Nhận này không miễn cho khách hàng nghĩa vụ trả chi phí dịch vụ điện. Tôi hiểu rằng trong trường hợp việc sử dụng máy móc trợ sinh được ghi trong Giấy Chứng Nhận này, việc gia hạn dịch vụ điện cho trường hợp không trả tiền sẽ được quyết định tùy theo từng trường hợp và sẽ không vượt quá 30 ngày. Tôi cũng hoàn toàn hiểu rằng dịch vụ điện có thể bị chấm dứt nếu tôi không trả tiền theo thỏa thuận.

Tôi hiểu rằng Giấy Chứng Nhận này chỉ có giá trị trong khoảng thời gian mỗi nguy hiểm đến tính mạng hoặc sức khỏe được chứng nhận là có hiện diện và không có giá trị trong quá một năm nếu không gia hạn.

Tên của Khách Hàng: \_\_\_\_\_

Địa chỉ nơi nhận dịch vụ: \_\_\_\_\_

Chữ ký của khách hàng: \_\_\_\_\_ Ngày: \_\_\_\_\_



## Seattle City Light

### CERTIFICATE OF MEDICAL NECESSITY

#### 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:

#### (Check all that apply)

- Ventilator (Continuous Mechanical)
- Oxygen Concentrator (Does not include liquid or cylinder oxygen use)
- Dialysis (In-home Peritoneal Dialysis only)
- CPAP or BIPAP device
- Nebulizer
- Suctioning device
- Dispenser (Feeding Pump or Medication Dispenser)
- Bed Mattress (Electric hospital bed or alternating pressure mattress)
- Chair (Electric lift chair or electric wheelchair, rechargeable)
- Other Life Support Equipment (Please specify type): \_\_\_\_\_
- 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).

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: \_\_\_\_\_

Healthcare Provider's I.D. Number: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Please Print): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

## 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 or a payment arrangement, 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.

Seattle City Light Account Number \_\_\_\_\_

Customer Name: \_\_\_\_\_

Service Address: \_\_\_\_\_

Customer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Self       Spouse       Parent or Guardian       Agent with Power of Attorney

Other please specify): \_\_\_\_\_

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

Primary Contact Number: \_\_\_\_\_

Secondary Contact Number: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

Other: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### MAIL Completed Certificate to:

Seattle City Light Credit Office, P.O. Box 34023, Seattle, WA 98124-4023

**OR FAX to:** Seattle City Light Credit Office at (206) 233-3748