**City Light (시티 라이트) 고객 서약서**

이 인증서에 적힌 사람은 전기로 작동하는 생명유지장치를 사용하는 자로서 아래 주소에 거주하는 주민입니다.

본인은 이 인증서가 고객의 전기 요금지불의 의무를 면제해 주지 않는 다는 것을 알고 있습니다.

본인은 이 인증서에 명시된 생명유지 장치의 용도를 알고 있으며, 전기 요금 미납 기간은 각 사례별로 결정되겠지만, 단, 30일을 초과하지 않을 것이라는 점을 알고 있습니다. 또한 본인은 전기 요금 미납으로 인해 전기 서비스가 중단 될 수 있음을 충분히 알고 있습니다.

이 인증서는 생명이나 건강상 위험의 존재가 인정되는 기간 동안만 유효하며, 그 기간을 갱신하지 않을 경우 1년 이상 유효하지 않음을 본인은 알고 있습니다.

고객 이름: _____

주　　소: _____

고객의 서명: _____ 날짜: _____

Seattle City Light

700 5th Ave. | P.O. Box 34023- Ste 2842 | Seattle WA 98124-4023
TEL (206) 684-3336 Customer Care Credit Department|
TTY/TDD (206) 684-3225 FAX (206) 287-5074 seattle.gov/light
twitter.com/SEACityLight facebook.com/SeattleCityLight

# 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