

MEDICAL CERTIFICATION FORM

PART A: To be completed by Customer

PART B and C: To be completed by Licensed Medical Professional, which includes: Medical Doctor (M.D./D.O.), Physician Assistant, Nurse Practitioner, or Board of Health.



PART A: CUSTOMER INFORMATION — Please complete all areas below

Account Holder's Name		Name of Person Using Equipment (Patient)	
Patient Relation to Account Holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
PSEG Long Island Account Number		Date of Birth (Patient)	
Street Address	City	State	ZIP Code
Primary Contact Number	Alternate Contact Number	Email Address	
Customer's Signature		Date	

PART B: LICENSED MEDICAL PROFESSIONAL CERTIFICATION — Please complete all areas below

LIFE SUPPORT EQUIPMENT INFORMATION — Life Support protection is based on **equipment usage, not condition or diagnosis**. Please indicate the type of life support medical equipment used and certify need:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Positive Pressure Respirator | <input type="checkbox"/> Respirators/Ventilators | <input type="checkbox"/> IV Feeding Machines | <input type="checkbox"/> Suction Machines |
| <input type="checkbox"/> Cuirass Respirators | <input type="checkbox"/> Rocking Bed Respirators | <input type="checkbox"/> IV Medical Infusion Machines | <input type="checkbox"/> Oxygen Concentrators |
| <input type="checkbox"/> Apnea Monitor (Infant) | <input type="checkbox"/> Tank Type Respirators | <input type="checkbox"/> Hemodialysis Machines | |

Other: _____
 I confirm that without the use of the equipment listed above, my patient would require **immediate hospitalization or be at risk of death**.
The following are generally **NOT** considered life support: oxygen PRN, sleep apnea machines for patients over 6 months of age (CPAP, BiPAP, APAP, VPAP), nebulizer, ICD, AED, pacemaker, spinal cord stimulator, life alert, air conditioning, refrigerated medication, electric bed, electric air mattress, electric lift and

PART C: Nature of Illness or Medical Condition — Please complete all areas below

Physician must document below, the serious illness or medical condition that severely affects the patient and questions wellbeing, the expected duration of the medical emergency and explanation of the nature of the medical emergency or the reason why the absence of utility service would impact the medical emergency.

Type of illness/medical condition	Expected duration
Explanation on how the absence of utility service would impact the illness/medical condition _____	

Licensed Medical Professional (Print Name)	Date Signed
Licensed Medical Professional (Signature)	Licensed Medical Professional - NYS License Number
Address	Contact Number

Affix Licensed Medical Professional's Stamp

Form should be returned to PSEG Long Island by:
Email: medicalnotes@psegliny.com **Fax:** 631-844-3635
Mail: PSEG Long Island
Attn: Customer Safeguard Solutions
15 Park Drive, Melville, NY 11747