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)**

Relation to Customer ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ 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:

☐ Positive Pressure Respirator
☐ Cuirass Respirators
☐ Apnea Monitor (Infant)
☐ Respirators/Ventilators
☐ Rocking Bed Respirators
☐ Tank Type Respirators
☐ IV Feeding Machines
☐ IV Medical Infusion Machines
☐ Hemodialysis Machines
☐ Suction Machines
☐ Oxygen Concentrators

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 electric wheelchair/lift.

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@pseg.com **Fax:** 631-844-3635
Mail: PSEG Long Island
Attn: Customer Safeguard Solutions
15 Park Drive, Melville, NY 11747