

# Notice of Life-Sustaining Equipment

**Account Number:** \_\_\_\_\_

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

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

**City/Town, Zip:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

*It is important that the account information listed above is correct. **Please Print.***

## Do you have life-sustaining equipment in your home?

- No.** Life-sustaining equipment is no longer in my home. Please remove my name from your list.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- Yes.** The following life-sustaining equipment is in my home:

Tank-type Respirator  
(Iron Lung)

Diaphragm Stimulator

Press Respirator

Heart Rate Monitor

Electrically Operated  
Respirator

Intermittent Positive  
Pressure Respirator

Cuirass-type Respirator  
(Chest)

Oxygen Concentrator

CPM Drum Ventilator

PD APNEA Monitor

Suction Machine (Pump)

Special Air Conditioner  
*(Please explain why  
you need this)*

Rocking Bed

Medical Pump

Hemodialysis Equipment  
(Kidney Machine)

- Other types of life-sustaining equipment or medical condition (Please be specific)

If you would like to authorize someone that we may discuss your account with other than yourself, please provide that party's information below.

**Third Party Name:** \_\_\_\_\_

**Third Party Address:** \_\_\_\_\_

**Third Party City, State, Zip:** \_\_\_\_\_

**Third Party Telephone:** \_\_\_\_\_