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HERE WITH YO .

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)
- ☐ Heart Rate Monitor
- ☐ Cuirass-type Respirator (Chest)
- ☐ PD APNEA Monitor
- ☐ Rocking Bed
- ☐ Diaphragm Stimulator
- ☐ Electrically Operated Respirator
- ☐ Oxygen Concentrator
- ☐ Suction Machine (Pump)
- ☐ Medical Pump
- ☐ Hemodialysis Equipment (Kidney Machine)
- ☐ Press Respirator
- ☐ Intermittent Positive Pressure Respirator
- ☐ CPM Drum Ventilator
- ☐ Special Air Conditioner *(Please explain why you need this)*

☐ 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: _____