



Notice of Life-Sustaining Equipment

Account Number: _____

Customer Name: _____

Service Address: _____

City/Town, Zip: _____

Telephone Number: _____

It is important the account number 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:

- | | |
|--|---|
| <input type="checkbox"/> Tank-type Respirator (Iron Lung) | <input type="checkbox"/> Heart Rate Monitor |
| <input type="checkbox"/> Curraisse-type Respirator (Chest) | <input type="checkbox"/> PD APNEA Monitor |
| <input type="checkbox"/> Rocking Bed | <input type="checkbox"/> Diaphragm Stimulator |
| <input type="checkbox"/> Electrically operated Respirator | <input type="checkbox"/> Oxygen Concentrator |
| <input type="checkbox"/> Suction Machine (Pump) | <input type="checkbox"/> Medical Pump |
| <input type="checkbox"/> Hemodialysis Equipment (Kidney Machine) | <input type="checkbox"/> Press Respirator |
| <input type="checkbox"/> Intermittent Positive Pressure Respirator | <input type="checkbox"/> CPM Drum Ventilator |
| <input type="checkbox"/> Special Air Conditioner (<i>Please explain why you need this</i>) | |

- 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: _____