

**Oraahda Macaamilka City Light**

Qofka lagu magacaabay Shahaadadaan kaasoo isticmaala qalabka ku shaqeeyo korontada ee lagu taageero nafta waa qof si joogto ah u daggan cinwaanka adeegga hoos lagu muujiyay.

Aniga waxaan fahamsanahay in Shahaadadaan aysan macaamilka ka dhaafi doonin bixinta kharashka adeegga korontada. Aniga waxaan fahamsanahay in marka Shahaadadaan xaqiiso jiritaanka isticmaalka qalabka lagu taageero nafta, go'aanka ku saabsan sii waddida adeegga korontada, xatta haddii aan la bixinin kharashka, saleeysan yahay qofka, mana ka badan doonto 30 maalin. Waxaan kaloo si buuxdo u fahamsanahay in ay dhici karto in la gooyo adeegga korontada haddii lagu fashalo bixinta kharashka sida lagu heshiiyay.

Aniga waxaan fahamsanahay in Shahaadadaan tahay sharci muddada la xaqiijiyay jiritaanka halista nafta ama caafimaadka, mana shaqeeyn doonto in ka badan hal sanno haddii aan la cusboneysiinin.

Magaca Macaamilka: \_\_\_\_\_

Cinwaanka Adeegga: \_\_\_\_\_

Saxiixa Macaamilka: \_\_\_\_\_ Taariikhda: \_\_\_\_\_



CERTIFICATE OF MEDICAL EMERGENCY

Physician’s Statement (Check One):

I certify that the person listed below uses recognized life support equipment requiring an electrical connection and that the termination of electrical service to their residence would create a life-threatening situation.

OR

I certify that the person listed below has a health-threatening situation involving a temporary illness or condition in which loss of electrical service could result in prolonging or exacerbating the illness or suspected illness.

Please complete the following:

1. Person’s Name: \_\_\_\_\_

2. Person’s Address: \_\_\_\_\_

3. Person uses the following life support equipment requiring an electrical connection:

(Check ALL that apply)

- VENTILATOR (Continuous Mechanical)
OXYGEN Concentrator (Does not include liquid or cylinder oxygen use)
DIALYSIS (In-home Peritoneal Dialysis only)
CPAP or BIPAP device
NEBULIZER
SUCTIONING Device
DISPENSER (Feeding Pump or Medication Dispenser)
BED-MATTRESS (Electric hospital bed or alternating pressure mattress)
CHAIR (Electric lift chair or electric wheelchair, rechargeable)
OTHER Life Support Equipment (Please specify type):
HEATING/COOLING (Patient is vulnerable to extreme temperatures due to serious long-term medical condition and patient’s health will be significantly endangered by the termination of electrical service for heating/cooling).

4. Person’s use of life support equipment is expected to be: (Check one)

- Short-term (Less than 60 days) Long-term (More than 60 days)

5. For temporary health-threatening situation NOT involving life support equipment, explain how the health of the person will be significantly endangered by the loss of electrical service:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Signature of Licensed Physician \_\_\_\_\_

Physician’s I.D. Number \_\_\_\_\_ Date \_\_\_\_\_

Name (Please Print) \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**City Light Customer's Statement**

The person named in this Certificate who uses electric-powered life support equipment is a permanent resident at the service address shown below.

I understand that this Certificate does not relieve the customer of the obligation to pay for electrical service. I understand that where the use of life support equipment is documented by this Certificate, the extension of electrical service for nonpayment will be determined on an individual basis and will not exceed 30 days. I also fully understand that electrical service may be terminated for failure to make agreed upon payment.

I understand that this Certificate is valid only for the length of time the life or health endangerment is certified to exist and that it is not valid for more than one year without renewal.

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

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

Customer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Statement of Person Using Life Support Equipment**

The information I have provided to the licensed physician is true, and I authorize the release of information on this certificate to Seattle City Light.

Name (print): \_\_\_\_\_

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

Relation to Person Using Life Support Equipment (**Check one**):

- Self       Spouse       Parent or Guardian       Agent with Power of Attorney
- Other please specify): \_\_\_\_\_

**Please list all phone numbers and your e-mail address and check the box next to your preferred method(s) of contact:**

- Home Phone: \_\_\_\_\_
- Work Phone: \_\_\_\_\_
- Cell Phone: \_\_\_\_\_
- Message Phone: \_\_\_\_\_
- Emergency contact number: \_\_\_\_\_
- Other: \_\_\_\_\_
- E-mail Address: \_\_\_\_\_

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**MAIL Completed Certificate to:**

Seattle City Light Credit Office, P.O. Box 34023, Seattle, WA 98124-4023

**OR FAX to:** Seattle City Light Credit Office at (206) 233-3748