

Declaración del Cliente de City Light

La persona cuyos datos aparecen en este Certificado, y que utiliza equipos eléctricos de respaldo de vida, es residente permanente en la dirección de servicios que se especifica más adelante.

Entiendo que este Certificado no exime al cliente de su obligación del pago por servicios eléctricos. Entiendo que donde se documenta el uso del equipo de respaldo de vida en este Certificado, la extensión del servicio eléctrico en caso de no haberlo cancelado, se determinará de forma individual y no excederá los treinta días. También entiendo por completo que el servicio eléctrico puede quedar suspendido en caso de incumplimiento del pago acordado.

Entiendo que este Certificado es válido sólo durante el tiempo que se certifique que exista vida o salud y que no es válido por más de un año sin renovación.

Nombre del Cliente: _____

Dirección del Servicio: _____

Firma del Cliente: _____ Fecha: _____



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-MATRESS (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: _____

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