

LIFE SUSTAINING EQUIPMENT CERTIFICATION

The certification form must be completed and signed by the attending medical professional. If approved for this program, the certification will be effective for 90 days from approval date.

1. Customer Information (REQUIRED)

- a. Customer Name _____
- b. Address _____
- c. Account Number _____
- d. Telephone Number _____

2. Patient Information (REQUIRED)

- a. Patient's Name (if different from above) _____
- b. Patient's Date of Birth _____
- c. Patient's Social Security Number _____

3. Medical Professional's Certification (REQUIRED)

- a. Medical Professional's Name _____
- b. Practice/Specialty _____
- c. Office Address _____
- d. Office Phone _____
- e. Office Email _____
- f. State License Number _____
- g. Last Examination Date _____

(should be within 3 months)

4. Medical Condition Information (REQUIRED)

- a. Does the patient use medical equipment that uses electricity? Yes /No
- b. Is there an alternate power source available? Yes/No
- c. Equipment Type _____
- d. Equipment is used _____ times per day; _____ hours per day
- e. Is this Life Sustaining equipment? Yes/No
- f. In the event of a power outage, will the patient be in an immediate life-threatening emergency? Yes/No
- g. Can this equipment be moved in the event of a power outage? Yes/No

Signature of Medical Professional

Date

Return form to: Atlantic City Electric - Revenue Recovery
5 Collins Drive
Carney's Point, NJ 08069
Fax: 888-254-1239
Email: acecreditbackoffice@exeloncorp.com