



LIFE-SUSTAINING EQUIPMENT CERTIFICATION

NOTE TO CUSTOMER: The certification form must be completed and signed by the attending physician. If approved for this program, this certification form will be effective for up to 1 year from the approval date. Please note: PSE&G may require an updated certification form prior to the expiration date. Please provide us with the customers correct email and phone number.

FORM MUST BE RETURNED WITHIN 15 DAYS

1. CUSTOMER INFORMATION ( REQUIRED )

Customer's Name:
Customer's Email:
Address:
Account Number:
Telephone Number:

2. PATIENT INFORMATION ( REQUIRED )

Patient's Name (if different from above):
Patient's Address (if different from above):
Patient's Telephone Number (if different from above):
Patient's Date of Birth:

3. PHYSICIAN'S CERTIFICATION ( REQUIRED )

Physician's Name:
Practice and/or Specialty:
Office Address:
Office Phone: Office Fax:
State License Number
Last Exam Date:

4. MEDICAL CONDITION INFORMATION ( REQUIRED )

Does the patient use medical equipment that requires electricity? :
Is there an alternate power supply available? :
Equipment Type:
Equipment Model Number:
Equipment is used: times per day; hours per day.
Is this Life Sustaining equipment?
In the event of a power outage, will the patient be in an immediate life-threatening emergency?
Can this equipment be moved in the event of a power outage?

Doctor's Signature

Please fax form to: PSE&G Priority 4 Coordinator at (973) 297-4311

Or mail to: PSE&G
P.O. Box 490
Cranford, NJ 07016
(Attention: Priority 4 Coordinator)