



## Notice of Life-Sustaining Equipment

Account Number: \_\_\_\_\_

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

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

City/Town, Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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"/> Curaisse-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: \_\_\_\_\_