Emergency Medical Equipment Notification Program.

NOTE TO CUSTOMER: The Licensed Medical Professional's Certification portion of this form must be completed and signed by the treating Licensed Medical Professional. Once approved, certification will be effective for 1 year. The Customer must complete the other portions of this form accurately and completely and return the completed form to:
Medical Equipment Program, Atlantic City Electric, 5 Collins Drive, Suite 2133, Carneys Point, New Jersey, 08069
Fax No. (888) 254-1239

CUSTOMER'S CERTIFICATION

Please Note: Submission of false or misleading information by the Customer may be actionable by law.

- Electric Account No:
  Name of Account Holder:
  Service Location:
  Telephone Number:

- Name of Person (the "Patient") who resides at service location listed above and who is the subject of the Licensed Medical Professional's Certification (below). _____

- Account Holder Signature:_____Date:_____

LICENSED MEDICAL PROFESSIONAL CERTIFICATION

NOTE TO LICENSED MEDICAL PROFESSIONAL: This Certification is required to assist Atlantic City Electric in determining whether there are special circumstances in providing electricity to the Patient listed above, with regard to outages, interruptions, or terminations of service (including terminations for non-payment). This Certification has legal implications. Please read it carefully and complete it accurately and legibly.

1. Licensed Medical Professional's Information: Name: _____

(Please print) State license: _____

Practice and/or specialties: _____

Office Address: _____

Office Phone: ( ) _____

2. I last examined the Patient on _____. (should be within 6 months of receipt)
(month/date/year)

3. Medical Equipment: The Patient ☐ **does** ☐ **does not** use medical equipment that requires electricity.

- medical equipment: _____
- medical equipment supplier:
  _____
- medical equipment is used for the following serious illness or other medical condition of the Patient.

_____

(*identify condition and/or diagnosis,and include any related conditions, symptoms or aggravations that bear on the Patient's need for the electrical medical equipment)*

- medical equipment must be used by the Patient for _____ hours per day, _____ days per week for a probable duration of_____; and the
- medical equipment ☐ **does** ☐ **does not** have a back-up power source and ☐ can ☐ cannot be operated manually.
- If applicable, backup will provide _____hours of operation

_____

REQUIRED - PLEASE CHECK ONE:

☐ **THE ABOVE-NAMED PATIENT USES LIFE-SUSTAINING EQUIPMENT POWERED BY ELECTRICITY AT THE SERVICE LOCATION IDENTIFIED ABOVE.**

☐ **THE ABOVE-NAMED PATIENT DOES NOT USE LIFE-SUSTAINING EQUIPMENT POWERED BY ELECTRICTY AT THE SERVICE LOCATION IDENTIFIED ABOVE.**

_____

I certify that I am a/the treating Licensed Medical Professional of the patient described above and that I have personal knowledge of the facts described herein regarding whether or not the patient has a serious illness or other medical condition that requires electrical medical equipment or life support or which would otherwise be aggravated by interruption or termination of electrical service. The information provided by me herein is true and accurate to the best of my knowledge, information and belief:

_____

Signature of Licensed Medical Professional Today's Date