LIFE SUPPORT CUSTOMER FORM

Please read through this form and fill out accordingly.

NAME OF PATIENT: **ACCOUNT NUMBER:**

HOME ADDRESS:

EQUIPMENT NEEDED:

Is this equipment necessary to sustain, restore, or supplement a vital function?

	Yes	No		Yes	No
Aerosol Tent	☐	☐	Intermittent Positive Pressure Breathing (IPPB)	☐	☐
Apnea Monitor	☐	☐	Motorized wheelchair	☐	☐
Compressor/Concentrator/Respirator	☐	☐	Oxygen generator	☐	☐
Electronic Nerve Stimulator	☐	☐	Pressure Pad/Pump	☐	☐
Electrostatic Nebulizer	☐	☐	Suction Machine	☐	☐
Hemodialysis/Kidney dialysis machine	☐	☐	Other, Please specify		

Why is the use of this equipment essential to sustain life or enhance mobility?

NAME OF PHYSICIAN: **BUSINESS PHONE:**

PHYSICIAN EMAIL: **BUSINESS ADDRESS:**

*** I CERTIFY THAT THE LIFE SUPPORT DEVICE(S) WILL BE REQUIRED FOR APPROXIMATELY:**

(COMPLETE ONE)

#OF YEARS OR ☐ PERMANENT

I herby certify that the above information is true and correct

Signature of Qualified Medical Professional

Physician License No

BEAR VALLEY ELECTRIC SERVICE, INC.

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