A PHI Company

Emergency Medical Equipment Notification Program.

NOTE TO CUSTOMER: The Physician's Certification portion of this form must be completed and signed by the treating physician. 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:
Pepco, 701 Ninth St, NW, RM7223, Washington DC 20068-0001
Fax No. (800) 461-9737

CUSTOMER'S CERTIFICATION

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

- Electric Account No:
  Name of Account Holder:
  Service Location:
- Name of person (the "Patient") who resides at service location listed above and who is the subject of the Physician's Certification (below). ____________________
- Account Holder Signature:____________________Date:____________________

PHYSICIAN'S CERTIFICATION

NOTE TO PHYSICIAN: This Certification is required to assist Pepco 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. Physician's Information: *(Please print)*
   Name: ____________________
   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' need for the electrical medical equipment)
- medical equipment must be used by the Patient for ______ hours per day, _______ days per week; 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:
IN THE EVENT OF A POWER FAILURE TO THIS EQUIPMENT, THE ABOVE NAMED PATIENT

❑ **WOULD BE** PLACED IN AN IMMEDIATE LIFE-THREATENING EMERGENCY

❑ **WOULD NOT BE** placed in immediate danger; however, he/she should have a back-up plan for extended power outages

I certify that I am a/the treating physician 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:

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Signature of Physician   Today's Date