

PHYSICIAN'S STATEMENT

Date: _____

Patient: _____

Address: _____

Owensboro, KY _____

Please describe the type of life support the above named uses:

Would this person face a life-threatening situation if their residence were without electricity? YES _____ NO _____

If on a machine or oxygen, does it require electricity to operate? YES _____ NO _____

Is there a battery back up for the system? YES _____ NO _____

In a 24 hour day, how many hours is the patient on the machine? Number of hours _____

Physician: _____

Address: _____

Physician's signature