



P.O. Box 400  
 Portland, Oregon 97207-0400  
 1-888-221-7070  
 fax 1-877-283-7697  
 pacificpower.net

**Pacific Power Medical or Life Support Equipment Certificate**

This certificate must be completed by a qualified medical professional certifying that a customer of Pacific Power, or a member of a customer's household, has a medical condition that would be adversely affected if their electric service is disconnected for nonpayment of bills.

Completion of this form allows Pacific Power to assist the customer in managing their electricity bills beyond what is normally allowed.

This certificate does not guarantee that power won't be interrupted from weather related outages, other circumstances outside of Pacific Power's control, or disconnection of service for nonpayment of bills. We recommend that one or more emergency plans be identified if deemed necessary.

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

Customer Pacific Power Account #: \_\_\_\_\_

Customer Address: \_\_\_\_\_

**THE FOLLOWING IS TO BE COMPLETED BY A QUALIFIED MEDICAL PROFESSIONAL:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Relationship to Customer: \_\_\_\_\_

Check one box below and provide the required information.

**If electric service is not available due to nonpayment of electric bills, the patient will:**

**Be inconvenienced and it will cause or aggravate a serious illness or infirmity, but their life will not be in immediate danger.**

Patient's medical condition: \_\_\_\_\_ Duration of condition: \_\_\_\_\_

Type of medical equipment used: \_\_\_\_\_

**OR**

**Require immediate response from emergency personnel with life supporting equipment to sustain life.**

Patient's medical condition: \_\_\_\_\_

Type of life support equipment used: \_\_\_\_\_

I have completed the entire form to the best of my knowledge. I understand this will not guarantee uninterrupted electrical supply and my patient will be responsible to make alternative arrangements in case of loss of electrical supply.

Print Name and Title: \_\_\_\_\_ Registration #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_ Telephone \_\_\_\_\_

**Please mail or fax the completed certificate to Pacific Power at:**

Mailing Address:	Pacific Power	Fax Number:	Attention: Medical Certificates
	Attention: Medical Certificates		1-877-283-7697
	PO Box 400		
	Portland, Oregon 97207-0400		

our true strength is  
**our connection to you**