Notice of Life-Sustaining Protection Form

Rhode Island Energy®
a PPL company

If you or someone in your household has a serious illness or disability and relies on life-sustaining, electrically-powered medical equipment as part of their weekly healthcare regimen, and you are requesting protection from electric service termination, please complete the attached Notice of Life-Sustaining Equipment form.

We also require that you complete the attached Financial Hardship Statement, along with either the attached Serious Illness Protection Form **OR** the attached Disabled Protection Form as part of your request for protection from electric service termination.

The forms can be sent to us using one of the methods below.

Online: Visit us online at RIEnergy.com/Protections to securely upload this completed form.

Fax: 401-955-6617

Mail: Rhode Island Energy
PO Box 25215
Lehigh Valley, PA 18002-5215

Note that the initial protection from termination for life-sustaining equipment cannot exceed six months. For longer protection, you must apply to the Division of Public Utilities & Carriers at:

Rhode Island Division of Public Utilities and Carriers
89 Jefferson Boulevard
Warwick RI 02888
401-780-9700

Account Holder's Name	**Electric Account Number:** **Gas Account Number:** **(account numbers must be at the same premise)**
Service Address	**Phone Number**
	Email Address

This information below must be completed by a Licensed Physician (LP), Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN) only. PLEASE PRINT

The following life-sustaining, electrically-powered medical equipment is in the home of the Life Support Dependent person identified above:

- ❑ Tank-Type Respirator (Iron Lung)
- ❑ Heart Rate Monitor
- ❑ Curaisse-type Respirator (Chest)
- ❑ CPAP Monitor
- ❑ Rocking Bed
- ❑ Medical Pump
- ❑ Hemodialysis Equipment (Kidney Machine)
- ❑ Diaphragm Stimulator
- ❑ Electrically Operated Respirator
- ❑ Oxygen Concentrator
- ❑ Suction Machine (Pump)
- ❑ Press Respirator
- ❑ Respirator CPM Drum Ventilator
- ❑ Intermittent Positive Pressure

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❑ Other types of life-sustaining, electrically-powered medical equipment (please be specific):

I certify the above-mentioned individual, at the address above, has a serious illness or disability and must rely on life-sustaining, electrically-powered medical equipment identified above as part of their weekly healthcare regimen through the date specified above.

Patient's Name	**Patient's Illness & Duration of Illness**
Physician's Name	**Physician's License Number**
Name & Address of Practice	
Licensed Physician's Signature & Title	**Date** (must be dated within the past 30 days)

If you would like to authorize someone that we may discuss your account with other than yourself, please provide that party's information below.

Third Party's Name	**Third Party's Phone Number**
Third Party's Address	

_____ _____

Accountholder's Signature **Date**