PUGET SOUND ENERGY

Life Support Request Form

TO BE COMPLETED BY THE CUSTOMER: (REQUIRED)

Account Number: ____

Account Holder's Name: ____

Patient's name (if different than account holder):______________________________
(Please Print)

Service Address: ____

Phone Number: (____) __________________ Cell Phone? ☐ Yes ☐ No

Email Address: ____

Customer Signature: ____

TO BE COMPLETED BY A MEDICAL PROFESSIONAL: (REQUIRED)

Medical Provider Name: ____
(Please Print)

Address: ____

Phone: (_____) ________________________ Fax: (_____)______________________

Please check all that apply:

☐ Dialysis
☐ Oxygen Concentrator
☐ Ventilator
☐ Infusion Feeding Pump
☐ Apnea Monitor: Adult /Infant
☐ Respirator
☐ Pressure Breathing Therapy
☐ Other (please specify): ____________

Frequency of Use: ____

Check box if statement is true: I confirm this is life supporting equipment ☐

Medical Professional Signature:____

Medical Professional Title: ______________________________ Date: ___________________

To return this form:

Email
CC-Medical@pse.com

Fax
425-424-6728
Attention Life Support

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