PART 2: TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR (MD), DOCTOR OF OSTEOPATHY (DO), PHYSICIAN ASSISTANT (PA) OR NURSE PRACTITIONER (NP)

I certify that the medical condition and needs of my patient *(please print):*

Patient's Last Name:		First Name:	

1. REQUIRES USE OF ELECTRICALLY-OPERATED MEDICAL DEVICES *(check one)* ○ Yes ○ No

The following electrically-operated medical device(s) is (are) used in the above-named patient's home:

Device:		○ Electricity	○ Gas
Device:		○ Electricity	○ Gas
Device:		○ Electricity	○ Gas

2. REQUIRES HEATING AND COOLING:

Standard Medical Baseline Allowances are available for heating and/or cooling if the device is medically necessary to sustain the patient's life or prevent deterioration of the patient's medical condition. The device must run on gas or electricity supplied by SCE. Devices used for therapy do not qualify.

Requires Standard Medical Baseline Allowance for heating: *(check one)* ○ Yes ○ No

Requires Standard Medical Baseline Allowance for cooling: *(check one)* ○ Yes ○ No

3. IS THE PATIENT UNDER HOSPICE CARE: *(check one)* ○ Yes ○ No

4. IF THE EQUIPMENT IS FOR LIFE-SUPPORT PURPOSES, PLEASE INDICATE BELOW THE PATIENT'S TOLERANCE TIME ABSENT THE EQUIPMENT: *(check one)*

○ 2 Hours or Less ○ More Than 2 Hours

5. I CERTIFY THAT THE MEDICAL DEVICE(S) AND/OR ADDITIONAL HEATING OR COOLING WILL BE REQUIRED FOR APPROXIMATELY: *(check one)* ○ No. of Years _____ or ○ Permanently

MD, DO, PA, NP Name *(please print)*:		Phone:	( )
Office Address:			
MD, DO, PA, NP State License or Military License Number:			
Signature of Doctor (MD, DO, PA, NP *signature only):*		Date: mm/dd/yy	

SCE reserves the right to verify information contained on this application with the authorizing physician.

MAIL APPLICATION TO:

Southern California Edison Company
Medical Baseline Department
P.O. Box 9527
Azusa, CA 91702-9954