LCEC LIFE SUPPORT SERVICE PROGRAM

In order for LCEC to determine whether a customer is eligible for designation as a Life Support Service ("LSS") Customer, Part A must be completed and signed by the Customer and the Patient or Guardian (if other than the Customer). Part B is to be completed by the Patient's physician and the entire form consisting of both Part A and Part B returned directly to LCEC at the following address:

LCEC, Attn: LCEC – Life Support Service Program, Post Office Box 3455, Fort Myers, FL 33918-3455

	OMER APPLICATION		
LCEC Account No.:			
Customer Name:	Social Security No).:	
Service Address:			
City, State, Zip:			
Daytime Area Code & Telephone Nos.:	and/or		
Name of Person Using Equipment:	Patient's Physician:		
Service Address: City, State, Zip: Daytime Area Code & Telephone Nos.: Name of Person Using Equipment: To the best of my knowledge and belief, the Patient identified above i continuously or as circumstances require as specified by the Patient's permanent resident at the Service Address identified above. I agree explained how my account will be handled regarding any collection guarantee uninterrupted service or assign a priority status to my account with backup medical equipment and/or power and a planned course of federal, state, or local governmental authorities whose duties or function entities authorized by congressional charter to assist in disaster relief the LSS customer name and service address. However, I also understand that LCEC has no obligation to release this LSS information to an information on this form, I must contact LCEC to request a Notice of Ereturned to LCEC, as provided with the Notice of Exclusion From Disc Notice. If I wish to ensure that the LSS and/or any additional inform contact the relevant authorities and provide the LSS and/or additional ir related to the disclosure of my information by or to LCEC, or any failuand whether or not the LSS information was requested.	is medically dependent on el- physician to avoid the loss of e to notify LCEC when this n action due to non-paymer int for service restoration duri f action in the event of prolon stions include emergency res efforts, may disclose to such stand that LCEC may not rec y such entity. In order to be Exclusion From Disclosure. T closure, and will be effective nation regarding the Patient's information myself. I agree to	ectric-powered e life or immediate equipment is no nt of the bill. I u ing outages. I an iged outages. I ac ponse or disaste n requesting entit ceive any such re excluded from the The Notice of Exc upon LCEC's rec s condition is fur hold LCEC harm	quipment that must be operated a hospitalization. The Patient is a longer in use. LCEC has fully inderstand that LCEC does not derstand that I must be prepared gree that LCEC, upon request of er relief or prevention, or private y the following LSS Information: e quests for this LSS Information: e disclosure by LCEC of the LSS clusion From Disclosure must be seipt of such properly completed nished to any such entity, I will alless from any claim based on or
	Date:		20
Customer Signature			
	Date:	1	20
Patient's or Guardian's Signature (if other than the Customer)			
WARNING - PART A - CUSTOMER APPLICATION: Knowingly making could result in the denial or termination of the medically essential servi		ent in completing	g the Customer Application
Part B: PHYSI	CIAN'S CERTIFICATE		
Physician's Name:F	Physician's License #:		
Dhysiain's Address:	Trysician's License #		
Physician's Address:Physician's Area Code & Telephone Nos.:	and/or		
I,, duly licensed and at	uthorized to practice medicing		
[Name of physician]	attionized to practice inculoin	J,	
[Name of physician]			
hereby certify that who re-	sides at		
hereby certify thatwho respectively service that	ithin the past 12 months, and ecified below in order to av	d depends upon void the loss of	electric-powered equipment that his/her life or serious medical
The patient uses this equipment forhours within each twenty-fou patient needs the continuous or specified use of this equipment in orchis/her immediate hospitalization: (Attach additional pages if necessary	der to avoid the loss of his/he	wing medical con er life or serious	dition is why, in my opinion, this medical complications requiring
Physician's Signature:	Date:		20
Physician's Signature: WARNING - PART B - PHYSICIAN'S CERTIFICATE: False certification	Date.	and the same of the same	20
(1)(h)or s. 459.015(1)(i), Fla. Stat. and constitutes grounds for discipling	n of medically essential service, penalties and/or enforcem	ent.	is a violation of S. 458.337

This certificate shall be deemed valid for a period of twelve (12) months from the date the certificate is accepted by LCEC for purposes of determining that a customer qualifies as a Life Support Service Customer within the meaning of Section 1.65 of the Company's General Rules and Regulations for Electric Service, or that such designation should be renewed. LCEC reserves the right to verify the accuracy of the information provided on this Physician's Certificate.