Date: [Date]

To: [Utility Company Name]
Department: Medical Emergency/Life Support Registry
Address: [Utility Company Address]

RE: Notice of Life-Sustaining Medical Equipment

Account Holder Name: [Name on Account]
Service Address: [Full Service Address]
Account Number: [Utility Account Number]

To Whom It May Concern,

I am writing to formally notify [Utility Company Name] that a resident at the above address requires the use of a life-sustaining medical device. Specifically, the patient utilizes a **Continuous Positive Airway Pressure (CPAP/BiPAP) machine** to treat severe Obstructive Sleep Apnea.

This medical equipment is essential for the patient's respiratory health and safety. A continuous supply of electricity is required to operate this device during sleep hours. A loss of power poses a significant health risk to the patient.

Please update your records to include this address in your **Medical Emergency Registry** or **Critical Care Program**. I request the following protections as provided by state regulations and company policy:

- Priority restoration of service following a power outage.
- Advanced notification of any scheduled maintenance or planned service interruptions.
- Protection against service disconnection for non-payment without extensive prior notice.

Attached to this letter, please find a signed certification from the treating physician confirming the medical necessity of this equipment.

Please confirm in writing once this account has been flagged for medical protection.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Phone Number]

Physician's Certification (To be completed by Doctor)

Patient Name: [Patient Name]
Medical Condition: Severe Obstructive Sleep Apnea
Required Equipment: CPAP/BiPAP Machine

I certify that the above-named patient requires the use of the listed life-sustaining equipment, which relies on a continuous utility supply. In the event of a power interruption, this patient's health would be seriously endangered.

Physician Name: _____
License Number: _____
Clinic Name: _____
Phone Number: _____

Physician Signature: _____ **Date:** _____