# PHYSICIAN'S STATEMENT

**OMU Customer Information**:
Name: _____ Phone #:_____
Address: _____ Acct #:_____

**Patient Information:**
Name: _____
Address: _____

Please briefly describe the patient's medical condition:
_____
_____
_____

Type of equipment used:
_____
_____

Frequency of use (Examples: Continuous, Daily for 8 hours, 5 times a day for 1 hour each time):
_____
_____

Would this person be in an immediate life-threatening situation if their residence were without electricity?
YES_____ NO_____

If on a machine or oxygen, does it require electricity to operate?
YES_____ NO_____

Is there a battery back up for the system?
YES_____ NO_____

Is medical equipment portable?
YES_____ NO_____

**Physician Information:**
Name: _____ Phone #: _____
Address: _____

_____ _____
Physician's Signature Date