



**PART 1 TO BE COMPLETED BY CUSTOMER (please print)**

PG&E Customer Account No: \_\_\_\_\_

Customer Name (as it appears on your bill): \_\_\_\_\_

Medical Baseline Resident's Name (if different): \_\_\_\_\_

Service Address: \_\_\_\_\_

Customer Mailing Address (if different): \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

**For Customers Billed by Someone Other Than PG&E**

Name of Mobile Home or Apartment Complex: \_\_\_\_\_

Complex Address: \_\_\_\_\_

Complex Manager's Name: \_\_\_\_\_ Complex Phone: (    ) \_\_\_\_\_

Name of Tenant: \_\_\_\_\_ Tenant's Phone: (    ) \_\_\_\_\_

**I understand that:**

1. If the doctor certifies the resident's medical condition is permanent, PG&E will require completion of a form self-certifying continued resident's eligibility for Medical Baseline every two years.
2. If the doctor certifies the resident's medical condition is not permanent, PG&E will require completion of a form self-certifying continued resident's eligibility for Medical Baseline each year and completion of a new application with a doctor's certification every two years.
3. If the resident has a vision disability, I may contact PG&E to request special notification when either re-certification (to complete a new application with a doctor's certification) or self-certification forms are mailed.
4. PG&E cannot guarantee uninterrupted gas and electric service and I am responsible for making alternate arrangements in the event of a gas or electric outage.

I certify that the above information is correct. I also certify that the Medical Baseline resident lives full-time at this address, and requires or continues to require the Medical Baseline Allowance. I agree to allow PG&E to verify this information. **I also agree to promptly notify PG&E if the qualified resident moves or Medical Baseline Allowance is no longer needed by the resident.**

Customer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The Standard Medical Baseline Allowance is 16.438 kilowatt-hours of electricity and/or 0.82192 therms of natural gas per day, which is in addition to your daily standard Baseline Allocation. If this allowance does not meet your medical needs, please contact PG&E at 1-800-743-5000 to discuss additional amounts.**

**PART 2 TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR (M.D.) OR DOCTOR OF OSTEOPATHY (D.O.)**

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

\_\_\_\_\_  
*Last Name*

\_\_\_\_\_  
*First Name*

**1. Requires use of a life-support device\* (check one)**       **Yes**       **No**

The following life-support device(s) is/are used in the above named patient's home:

Device: \_\_\_\_\_  Electricity       Gas

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Device: \_\_\_\_\_  Electricity       Gas

\*A qualifying life-support device is any medical device used to sustain life or is relied upon for mobility. This device must run on gas or electricity supplied by PG&E. It includes, but is not limited to, respirators (oxygen concentrators), iron lungs, hemodialysis machines, suction machines, electric nerve stimulators, pressure pads and pumps, aerosol tents, electrostatic and ultrasonic nebulizers, compressors, IPPB machines, kidney dialysis machines, and motorized wheelchairs. **Devices used for therapy rather than life-support do not qualify.**

**2. Requires heating and cooling:**

Standard Medical Baseline Allowances are available for heating and/or cooling if patient is Paraplegic, Quadriplegic, Hemiplegic, has Multiple Sclerosis or Scleroderma. Standard Medical Baseline Allowances are also available if patient has a compromised immune system, life threatening illness, or any other condition for which **additional heating or cooling is medically necessary to sustain the person's life or prevent deterioration of the person's medical condition.**

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

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

**3. I certify that the life support device(s) and/or additional heating or cooling will be required for approximately:**

(complete one)       **No. of Years** \_\_\_\_\_ **or**       **Permanently**

Doctor's Name: \_\_\_\_\_ Phone No. (    ) \_\_\_\_\_

Office Address: \_\_\_\_\_

MD/DO California State License or Military License Number: \_\_\_\_\_

Signature of Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

*FOR PG&E USE ONLY*    Date Received: \_\_\_\_\_    Medical Baseline Allocation: \_\_\_\_\_    Electric unit(s) \_\_\_\_\_    Gas unit(s) \_\_\_\_\_

Recertification:       *Self-certify every 2 years*       *Self-certify annually; Doctor's certification every 2 years*

Mail application to: *Pacific Gas and Electric Company, P.O. Box 8329, Credit & Records Center - Medical Baseline, Stockton, CA 95208*