



Please send the completed form to;  
 SA Power Networks,  
 Revenue Services DX11101  
 GPO Box 77, Adelaide, 5001  
 or Fax to 08 8404 9355

## Notification of installation/removal of life support equipment South Australia

By completing this form you accept that your electricity retailer and SA Power Networks will share the relevant information about you and your supply address for the purposes of updating their records and registers. *You also agree to inform your electricity retailer and SA Power Networks if the person for whom the Life Support Equipment is required vacates the supply address or no longer requires the Life Support Equipment by contacting us on 13 12 61.* You also acknowledge that registering as a life support address does not guarantee supply and in particular your supply will still be subject to outages due to storms, accidents or other circumstances beyond SA Power Networks' and your retailer's control.

Registration is available to the following life support equipment types (as specified in the National Energy Retail Rules).

Please indicate which type is in use at your address by ticking the appropriate box.

- An oxygen concentrator;
- An intermittent peritoneal dialysis machine;
- A chronic positive airways pressure respirator;
- Other (please specify).....
- A kidney dialysis machine;
- A ventilator for life support;
- Crigler Najjars Syndrome phototherapy equipment;

|  |   |             |             |           |
|--|---|-------------|-------------|-----------|
| Mr/Mrs/Ms/Miss   | Surname   |             | Given name  |           |
| Residential ( Supply ) Address   | Street/Lot Number   | Street Name | Suburb/Town | Post code |
| Postal Address   | Street/Lot/PO Box   | Street Name | Suburb/Town | Post code |
| Phone Contact  | Home  | Work        | Mobile      |           |
| National Metering Identifier (NMI) – from electricity bill<br>200_ _ _ _ _ / _ |   | Email       |             |           |
| Customer Signature   | I accept the conditions above and certify that the details provided are correct |             | Date        |           |

|                                 |      |       |
|---------------------------------|------|-------|
| Carer details ( if applicable ) | Name | Phone |
|---------------------------------|------|-------|

### Medical Practitioner/Hospital Certification

I (Doctor/Medical Practitioner).....hereby certify a person residing at the above supply address requires the Life Support Equipment as indicated above.

Signature and Stamp of Medical Practitioner.....Date.../... /.....