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;

☐ A kidney dialysis machine;

☐ An intermittent peritoneal dialysis machine;

☐ A ventilator for life support;

☐ A chronic positive airways pressure respirator;

☐ Crigler Najjars Syndrome phototherapy equipment;

☐ Other (please specify).....

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 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..../... /.....