

LIFE SUPPORT EQUIPMENT REGISTRATION

Providing false, incomplete or misleading information may result in the address not being registered as a property where life support equipment is required. This means that the resident will not be subject to life support equipment protections.

Section 1: Person requiring life support equipment at the property

First name _____ Surname _____
Date of birth _____ Unit or site no. _____
Contact email _____ Contact phone _____

Section 2: Address where life support equipment is required

Unit or site no. _____ Building/House No _____
Complex name _____ Street name _____
Suburb _____ Postcode _____

Section 3: Occupier of the property where life support equipment required

Is the person listed above the occupier of the property who should be contacted regarding outages?

Yes No If 'No', please complete the following

Occupier's first name _____ Occupier's surname _____
Relationship to person requiring life support equipment _____
Occupier's contact phone no. _____ Occupier's contact email _____

SECTION 4: DECLARATION (to be filled in by person requiring life support equipment or authorised person)

I hereby declare that:

- 1) I am the person named in Section 1 above, or if not, I am authorised to act on that person's behalf for the purpose of this application.
- 2) All information provided in this life support equipment application is, to the best of my knowledge and belief, true, accurate and not misleading.
- 3) I will notify Enpowered in writing if life support equipment is no longer required at the property identified in Section 1.
- 4) I will notify Enpowered of any changes to the contact details specified in Section 3.
- 5) I consent to:
 - a) Enpowered providing information concerning the person(s) named in Sections 1 and 3 and/or this application to the Enpowered electricity retailer and relevant government agencies; and
 - b) Enpowered providing that information to the network operator and relevant government agencies, for purposes related to this life support equipment application.
- 6) I acknowledge and agree that I will be required to renew this life support equipment application:
 - a) annually (without requiring production of medical certification unless requested); and
 - b) every three years (with medical certification).

Signature _____ Date _____

Name (please print) _____

Please note: If a person requires life support equipment, they may also be eligible for the Life Support Equipment Electricity Subsidy Scheme. More information on the Scheme is available from:

http://www.finance.wa.gov.au/cms/State_Revenue/ECES/Energy_Subsidy_Schemes.aspx

SECTION 5: ON-SELLER'S DETAILS (to be filled in by Empowered)

Electricity retailer _____ Retailer account number _____

Name (as it appears on the bill) _____

Supply address: (as it appears on the bill) _____

Postal address (if different to above) _____

Contact email address _____ Contact phone number _____

On-seller's declaration (to be filled in by Empowered)

- 1) I am the electricity on-seller named in Section 5, above.
- 2) I will use and share the information contained in this life support equipment application in accordance with the conditions of my electricity retail licence exemption, and for no other purpose.
- 3) I will store this life support equipment application in a secure location.

Signature _____ Date _____

Name (please print) _____ Title _____

Medical Practitioner

This section must be completed by one of following types of medical practitioner:

- Specialist medical practitioner or a practitioner working in a specialist department of a hospital OR,
- Hospice doctor OR,
- If outside the Perth metropolitan area, a Doctor/General Practitioner working on an occasional basis from a local hospital/rural health service.

I, _____ (insert full name of Medical Practitioner) confirm that
_____ (insert full name of patient) is a patient of mine and I have
prescribed the following equipment necessary for the continuation of life for use at the address specified above.

Life support equipment type	Yes/No	Life support equipment type	Yes/No
Ventilator (VPAP or BPAP, or CPAP if required as life support equipment*)		Apnoea Monitor (for children only) **	
Oxygen Concentrator Standard Capacity – (Child) **		Heart Pump	
Oxygen Concentrator Standard Capacity – (Adult)		Nebuliser (children– used every day for 1-2 hours per day) **	
Oxygen Concentrator High Capacity “New Life Intensity” (Adult)		Nebuliser (adult – prescribed when a tracheostomy is expected to be in place for more than 6 months where nebulised therapy is required for life support purposes)	
Feeding Pump		Machine Assisted Peritoneal Dialysis Equipment (cyclor or heater)	
Suction Pump			

* Only CPAP machines that are clinically prescribed for severe obstructive sleep apnoea critical for life support with use for over four hours per night are eligible

** A child is defined as being under the age of 16 years

Medical practitioner signature _____ Date _____

Medical practitioner name _____ Position title _____

Phone no. _____ Medical registration no. _____ Stamp (if available) _____

Name of hospital / hospice / rural health service _____