

# LIFE SUPPORT EQUIPMENT ADDRESS REGISTRATION – ELECTRICITY ON-SELLER PREMISES

Providing false, incomplete or misleading information may result in the address not being registered as a property where life support equipment is required, meaning the resident will not be subject to the 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 the electricity on-seller in writing if life support equipment is no longer required at the property identified in Section 1.
4. I will notify the electricity on-seller of any changes to the contact details specified in Section 3.
5. I consent to:
  - a) the electricity on-seller providing information concerning the person(s) named in Sections 1 and 3 and/or this application to the on-seller's electricity retailer and relevant government agencies; and
  - b) the on-seller's electricity retailer 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](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 the electricity on-seller)**

Electricity retailer		Account number	
Name (as it appears on your bill)			
Supply address: (as it appears on your bill)			
Postal address (if different to above)			
Contact email address		Contact phone number	

**On-seller's declaration (to be filled in by the electricity on-seller)**

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)			

**Medical practitioner declaration**

*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 \_\_\_\_\_ (Full name of Medical Practitioner) confirm that \_\_\_\_\_ (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			
Suction Pump		Machine Assisted Peritoneal Dialysis Equipment (cycler or heater)	

\* 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				