MEDICAL CONFIRMATION FORM

Date of Issue	
Customer Name	
Account Number	

SECTION A: INFORMATION FOR THE CUSTOMER

To ensure you receive the necessary protections for premises with life support equipment, please complete and return this form to Microgrid Power. This will satisfy the requirement to provide medical confirmation under the National Energy Retail Rules (**NERR**).

You are required to return this completed medical confirmation form to Microgrid Power. The medical confirmation must be signed and dated no more than 4 years before the date you told us about the life support requirement, and it must be legible.

You may request an extension of time to complete and return this medical confirmation form. You are entitled to at least one extension of time to provide medical confirmation, and any extension we give you must be at least 25 business days.

If you require additional time, please contact us on 1800 647 888 or support@microgridpower.com.au.

If you ask us for a copy of the medical confirmation you have given us, we must provide it within 15 business days of your request.

For the purposes of this form, **'Life Support Equipment'** means any of the following:

- Oxygen concentrator
- Intermittent peritoneal dialysis machine
- Kidney dialysis machine
- Chronic positive airways pressure respirator
- Crigler-Najjar syndrome phototherapy equipment
- Ventilator for life support (life support ventilator)
- any other equipment that a registered medical practitioner certifies is required for a person residing at the customer's premises for life support.

SECTION B: CUSTOMER DETAILS

To be completed by the customer

Supply Address	
Date from supply of energy required at the premises for the purposes of Life Support Equipment	

SECTION C: MEDICAL PRACTITIONER CONFIRMATION

To be completed by a registered medical practitioner

I, _____ (registered medical practitioner), certify that the person named above requires the following life support equipment at the supply address listed above.
Type of Life Support Equipment Required (please tick or specify): ☐ Oxygen concentrator ☐ Intermittent peritoneal dialysis machine ☐ Kidney dialysis machine ☐ Chronic positive airways pressure respirator ☐ Crigler-Najjar syndrome phototherapy equipment ☐ Ventilator for life support ☐ Other equipment (please specify):

Medical Practitioner Name	
Practice Name	
Practice Address	

Contact Number	
Medical Practitioner Signature:	
Date:	

SECTION D: CUSTOMER DECLARATION

I declare that the information provided in this form is true and correct to the best of my knowledge.

Customer Signature:
Customer Name:
Date:

RETURNING THIS FORM

Please return this completed form to Microgrid Power by:

Email: support@microgridpower.com.au
Post: PO Box 634 Terrigal NSW 2260

If you have any questions about this form or the life support registration process, please contact us on 1800 647 888.

PRIVACY NOTICE

The personal information collected in this form is being collected by Microgrid Power for the purpose of registering your premises as requiring life support equipment. We are required to give the retailer for your premises, and any exempt distributor, the

fact that a person residing or intending to reside at your premises requires life support equipment, and the date from which it is required.

For more information about how Microgrid Power handles your personal information, including how you can access or correct your information or make a privacy complaint, please refer to our Privacy Policy available at www.microgridpower.com.au/documents or contact us on 1800 647 888.