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 as your exempt electricity seller. Completing and returning this form will satisfy the requirement to provide medical confirmation under the Energy Retail Code of Practice (ERCOP).

You are required to return this completed medical confirmation form to Microgrid Power.

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.

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)
- in relation to a particular customer, any other equipment (whether fuelled by electricity or gas) that a registered medical practitioner certifies is required for a person residing at the customer's premises for life support.

Other equipment may include, but is not limited to, the following:

- external heart pumps
- respirators (iron lung)
- suction pumps (respiratory or gastric)

- feeding pumps (kangaroo pump, or total parenteral nutrition)
- insulin pumps
- airbed vibrator
- hot water
- nebulizer, humidifiers or vaporizers
- apnoea monitors
- medically required heating and air conditioning
- medically required refrigeration
- powered wheelchair

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.