

OPIOID DEPENDENCY TREATMENT CENTRE LICENCE (PHARMACIST) APPLICATION

PURPOSE

This form is to be used to apply for a licence under the Medicines, Poisons and Therapeutic Goods Act 2008 (the Act). You can access the Act and its regulation at <u>www.legislation.act.gov.au</u>.

PRIVACY

The collection of personal information is required by this form for the purposes of issuing a licence under the Act. The Health Protection Service (HPS) prevents any unreasonable intrusion into a person's privacy in accordance with the *Privacy Act 1988* (Commonwealth).

HEALTH PROTECTION SERVICE CONTACT INFORMATION Trading Hours: 9.00am – 4.30pm Monday to Friday						
Website:	General Enquires:	Email Address:	Fax Number:			
www.health.act.gov.au/hps	(02) 5124 9700	hps@act.gov.au	(02) 5124 5554			

INSTRUCTIONS FOR COMPLETION & IMPORTANT INFORMATION

- No fee is required.
- The applicant should be familiar with the *Medicines, Poisons and Therapeutic Goods Act 2008* and Regulation 2008, the National Guidelines for Medication-Assisted Treatment of Opioid Dependence (2014) and the Opioid Maintenance in the ACT: Local Policies and Procedures.
- The applicant should also be familiar with training requirements that are outlined in the Medicines, Poisons and Therapeutic Goods (Guidelines for treatment of opioid dependency) Approval 2018 (No 1).
- Failure to comply with ACT legislation renders a person liable to prosecution.
- Information is collected for licence purposes and will not be provided to other parties without consent or unless otherwise required by law.
- The applicant must be a pharmacist at a community pharmacy.
- Complete this form using a black or blue pen only.

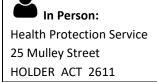
Confirmation of identity will need to be produced either:

- 1. In person at the Health Protection Service office; or
- 2. By submitting certified copies via post/email/fax to the HPS office.

TRANSLATING AND INTERPRETING SERVICE

A language assistance service is available by phoning the Translating and Interpreting Service (TIS) on 13 14 50.

COMPLETED FORMS TO BE RETURNED



By Post: Health Protection Service Locked Bag 5005 WESTON CREEK ACT 2611





(02) 5124 5554

CHECKLIST Part A completed and signed: Applicant Details Part B complete: Proof of identification One form of current photographic identification presented in person at the Health Protection Service OR One form of current photographic identification sighted and certified by an authorised witness Part C Licence application details: Copy of training certificate attached Declaration of suitability signed (page 6) Declaration signed (page 6)

PART A – APPLICANT DETAILS

TITLE (Mr, Ms, Dr, Prof)	GIVEN NAM	ES			FAMILY	NAME	
APPLICANT RESIDENTIAL ADDRESS (Property Name, Unit, Flat Number, Street Number, Street Name)							
CITY / SUBURB / TOWN	CITY / SUBURB / TOWN STATE /		E / TERRITORY		POSTCODE		
POSTAL ADDRESS (If differen	nt to above com	pany addre	ess)				
CITY / SUBURB / TOWN		STATE /	TERRITORY			POSTCODE	
HOME TELEPHONE NUMBER			MOBILE NUMBER				
WORK NUMBER EMAIL AD		DRESS					
AUSTRALIAN BUSINESS NU	MBER (A.B.N)	(if applice	able)				

DECLARATION SIGNATURE
I,, confirm that the information supplied on this page is true and accurate and understand that the provision of false or misleading information is an offence.
Signature:
Date: / /
Note for Multiple Applicants: (for example partnerships) Copies of Part B are available at <u>www.health.act.gov.au/hps</u> or by contacting the HPS.

PART B – PROOF OF IDENTIFICATION

One form of current photographic identification sighted and certified by an authorised witness must be provided for each signatory in Part A

A list of authorised witnesses for true and correct copy can be found at: http://www.ag.gov.au/Publications/Pages/Statutorydeclarationsignatorylist.aspx

The witness should include the following text on a certified copy:

EXAMPLE

CERTIFIED TRUE COPY OF THE ORIGINAL I certify that this is a true and accurate copy of the original document sighted by me. Full Name: _____Signed: ______Dated: _____Authority to sign: ______F

Phone:

ACCEPTABLE FORMS OF PHOTOGRAPHIC IDENTIFICATION – Examples below

Driver's licence Proof of age or identity card issued by a State/Territory Passport

FORMS OF IDENTIFICATION PROVIDED					
Туре	Number	Expiry Date	Certified Copy Attached		

PART C – LICENCE APPLICATION DETAILS – (must be completed)

PHYSICAL ADDRESS OF B	USINESS				
NUMBER:	PROPERT	Y NAME:			
STREET NAME:					
SUBURB:		STATE:		POSTCODE:	
COMMUNITY PHARMAC NUMBER:	Y LICENCE				
BUSINESS ONSITE CONTA	ACT PERSON				
GIVEN NAME:			FAMILY NAME:		
BUSINESS PHONE:			MOBILE PHONE:		
EMAIL ADDRESS:				FAX:	
APPLICANT'S PROFESSIO	NAL DETAILS (if app	olicable)			
OCCUPATION:					
PHARMACIST REGISTRAT	TION NUMBER:				
APPLICANT TRAINING IN APPLICANT HAS COMPLE COPY OF TRAINING CERT	TED REQUIRED TRAI		Yes No	,	
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Please ensure both declarations on page 6 are signed before submitting form.

DURATION OF LICEN	ICE		
Please select desired	duration of licence:		
🗌 - 1 Year	- 2 Years	3 Years	

Please ensure both declaration sections below are signed before submitting form.

DECLARATION OF SUITABILITY
 I declare that I am a suitable person to hold a licence because: I, a close associate or a corporation where I am an executive officer, has not been convicted or found guilty in the 5-year period before the day of application for the licence of an offence against the Act or an offence in Australia or elsewhere in relation to a regulated substance or regulated therapeutic good. I, or a close associate, are not an undischarged bankrupt now or were in the 5-year period before application, or have executed a personal insolvency agreement. I, or a close associate, were not involved in the management of a corporation in the 5-year period before application that became the subject of a winding-up order or an administrator was appointed for the corporation. NAME:
DECLARATION I declare that I am authorised to supply all the information above; that all the information supplied on this form is true and
correct; and that there are necessary records and/or documentation to support this licence application. I understand that failure to submit all required information and documentation may delay my application and that the
provision of false or misleading information may be a criminal offence. NAME:

SIGNATURE: ______

DATE: