ACT Government | ACT Health

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 www.legislation.act.gov.au.

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

In Person:	**By Post:**	**By Fax:**	**By Email:**
Health Protection Service 25 Mulley Street HOLDER ACT 2611	Health Protection Service Locked Bag 5005 WESTON CREEK ACT 2611	(02) 5124 5554	hps@act.gov.au

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 NAMES**	**FAMILY NAME**

APPLICANT RESIDENTIAL ADDRESS *(Property Name, Unit, Flat Number, Street Number, Street Name)*		
CITY / SUBURB / TOWN	**STATE / TERRITORY**	**POSTCODE**

POSTAL ADDRESS *(If different to above company address)*		
CITY / SUBURB / TOWN	**STATE / TERRITORY**	**POSTCODE**

HOME TELEPHONE NUMBER	**MOBILE NUMBER**

WORK NUMBER	**EMAIL ADDRESS**

AUSTRALIAN BUSINESS NUMBER (A.B.N) *(if applicable)*											

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 www.health.act.gov.au/hps 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: _____ 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

Type	Number	Expiry Date	Certified Copy Attached
			☐
			☐

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

TRADING NAME – ***If applicable***		
PHYSICAL ADDRESS OF BUSINESS		
NUMBER:	**PROPERTY NAME:**	
STREET NAME:		
SUBURB:	**STATE:**	**POSTCODE:**
COMMUNITY PHARMACY LICENCE NUMBER:		

BUSINESS ONSITE CONTACT PERSON	
GIVEN NAME:	**FAMILY NAME:**
BUSINESS PHONE:	**MOBILE PHONE:**
EMAIL ADDRESS:	**FAX:**

APPLICANT'S PROFESSIONAL DETAILS ***(if applicable)***
OCCUPATION:
PHARMACIST REGISTRATION NUMBER:

APPLICANT TRAINING IN OPIOID DEPENDENCY TREATMENT
APPLICANT HAS COMPLETED REQUIRED TRAINING COURSE: ☐ Yes ☐ No
COPY OF TRAINING CERTIFICATE ATTACHED: ☐ Yes ☐ No

Is the address for storage of methadone and buprenorphine the same as the physical address of the business?

☐ *No* ☐ *Yes* ***If <u>Yes</u> continue to SECURITY ARRANGEMENTS; If <u>No</u>, provide storage address below then detail security arrangements***

STORAGE ADDRESS		
NUMBER:	**PROPERTY NAME:**	
STREET NAME:		
SUBURB:	**STATE:**	**POSTCODE:**
CONTACT NAME:	**CONTACT NUMBER:**	

SECURITY ARRANGEMENTS

Please provide details.

<u>Please ensure both declarations on page 6 are signed before submitting form.</u>

DURATION OF LICENCE

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: _____ **SIGNATURE:** _____

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: _____ **POSITION:** _____

SIGNATURE: _____ **DATE:** _____