ACT Government | ACT Health

COMMUNITY PHARMACY APPLICATION TO VARY LICENCE

PURPOSE

This form is to be used to apply for a variation to a licence under the *Public Health Act 1997* (the Act).
You can access the legislation 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

- This application form must be signed by the licence holder.
- The original licence certificate must be attached to this application.
- All associated documentation must accompany this application.
- You cannot change premises location using this form. Please submit a new application.
- A *Community Pharmacy Application to Transfer Licence* form must be used to change a pharmacy's owner(s)/licensee.
- Complete this form using a black or blue pen only.

Note: It is an offence to make a false or misleading statement or give false or misleading information (see *Criminal Code 2002*, Part 3.4).

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 Howard Florey Centenary House 25 Mulley Street HOLDER ACT 2611	Health Protection Service Locked Bag 5005 WESTON CREEK ACT 2611	(02) 5124 5554	hps@act.gov.au

REQUIRED INFORMATION ***(must be completed)***		
LICENCE NUMBER:	**FILE NUMBER:**	**EXPIRY DATE:**
TRADING NAME: *(As appears on current licence certificate)*		

PARTICULARS OF BUSINESS VARIATION ***(must be completed)***

Please indicate which variation(s) you are applying for and ONLY complete the sections relevant to your changes.

☐ Trading Name ☐ Refurbishment ☐ Postal Address ☐ Contact Person

☐ Change in Directors of a Complying Pharmacy Corporation ☐ Change in Trust Beneficiaries of a Complying Pharmacy Corporation

☐ Change in Shareholders of a Complying Pharmacy Corporation

VARIATION IN TRADING NAME

NEW TRADING NAME: *(if applicable)*

REFURBISHMENT
Plans submitted via email to hps@act.gov.au must be no larger than A3 size.

Describe the nature of the structural change

(please tick the applicable box below)

☐ Detailed copies of plans for the new business are attached.

☐ Plans for the premises were previously submitted for assessment on ____ / ____ / _____

POSTAL ADDRESS:		
ROOM/ SHOP NUMBER/PO BOX:	**PROPERTY NAME:**	
STREET NAME:		
SUBURB:	**STATE:**	**POSTCODE:**

CONTACT PERSON ***(For all enquires or correspondence. MUST be one of the applicants)***		
GIVEN NAME:	**FAMILY NAME:**	
PHONE NUMBER:	**MOBILE PHONE:**	
AFTER HOURS PHONE:	**FAX:**	
EMAIL ADDRESS:		
ROOM/ SHOP No/PO BOX:	**PROPERTY NAME:**	
STREET NAME:		
SUBURB:	**STATE:**	**POSTCODE:**

NEW DIRECTOR DETAILS ***(only a pharmacist may be a director of a complying pharmacy corporation)***

REQUIRED INFORMATION

Is a copy of the current company extract (issued within the previous 30 days)from the Australian Securities and Investment Commission outlining new directors and shareholders for the complying pharmacy corporation attached? ☐ ***Yes***

Director 1
Name:
Pharmacist registration number (PHA):
Director 2
Name:
Pharmacist registration number (PHA):
Director 3
Family Name:
Given Name:
Pharmacist registration number (PHA):

Director 4
Family Name:
Given Name:
Pharmacist registration number (PHA):

Director 5
Family Name:
Given Name:
Pharmacist registration number (PHA):

Director 6
Family Name:
Given Name:
Pharmacist registration number (PHA):

If more than 6 directors, please attach information separately.

NEW SHAREHOLDER DETAILS - ***(A shareholder in a complying pharmacy corporation must be either a pharmacist or a close relative of a pharmacist shareholder)***

REQUIRED INFORMATION

Is a copy of the current company extract from the Australian Securities and Investment Commission outlining new directors and shareholders for the complying pharmacy corporation attached? ☐ ***Yes***

If a shareholder is a close relative to a pharmacy director/shareholder, is evidence to support this relationship attached?
(Examples include – birth certificate, marriage certificate or statutory declaration) ☐ ***Yes*** ☐ ***N/A***

Shareholder 1
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Shareholder 2
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Shareholder 3
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Shareholder 4
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Shareholder 5
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Shareholder 6
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

If more than 6 Shareholders, please attach information separately.

NEW TRUST BENEFICIARY ***(If applicable)***

(Where a pharmacy corporation acts as a trustee for a trust, all beneficiaries must be either a pharmacist who is a director or employee of the corporation or a close relative of the pharmacist.)

REQUIRED INFORMATION

Are all beneficiaries the same as the shareholders? ☐ ***Yes*** ☐ ***No***

If <u>YES</u> please proceed to the declaration section on page 5. If <u>NO</u> please provide all trust beneficiary details below.

Where a beneficiary is a close relative to a pharmacy director/shareholder, is evidence to support this relationship provided?
(Examples include: birth certificate, marriage certificate or statutory declaration) ☐ ***Yes*** ☐ ***N/A***

Is the trust deed for a pharmacy corporation that acts as a trustee for a trust attached? ☐ ***Yes***

TRUST NAME

TRUSTEES
Name:
Name:
Name

If more than three (3) Trustees, you must attach information separately.

Trust Beneficiary 1
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Trust Beneficiary 2
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Trust Beneficiary 3
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Trust Beneficiary 4
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Trust Beneficiary 5
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Trust Beneficiary 6
Family Name:
Given Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

If more than 6 Trust Beneficiaries, please attach information separately.

DECLARATION – *(Must be completed by all applicants)*			
I, the undersigned, understand my obligations as a licensee under the Public Health Act 1997 I declare that the particulars on this form are true and correct. 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.***			
1	Name:	Signature:	Date: / /
2	Name:	Signature:	Date: / /
3	Name:	Signature:	Date: / /
4	Name:	Signature:	Date: / /
5	Name:	Signature:	Date: / /
6	Name:	Signature:	Date: / /

If more than six applicants or directors you must attach signatures separately