PRESCRIBER ENDORSEMENT TO TREAT DRUG DEPENDENCY NEW APPLICATION

PURPOSE

This form is to be used to apply for an endorsement to treat drug-dependency 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 an endorsement 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) 6205 1700	hps@act.gov.au	(02) 6205 1705

INSTRUCTIONS FOR COMPLETION & IMPORTANT INFORMATION

An endorsement is issued to the person(s) who will have the overall responsibility for dealing with the medicine(s) or poison(s) authorised under the endorsement, including responsibility for any contraventions of the Act.

- **No fees apply to this application.**
- The applicant should be familiar with the *Medicines, Poisons and Therapeutic Goods Act 2008*, Medicines, Poisons and Therapeutic Goods Regulation 2008, the Controlled Medicine Prescribing Standards (Category 3), the National Guidelines for Medication-Assisted Treatment of Opioid Dependence (2014) and the Opioid Maintenance Treatment 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 endorsement purposes and will not be provided to other parties without consent, or if otherwise required by law.
- Complete this form using a black or blue pen.

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	Health Protection Service Locked Bag 5005	(02) 6205 1705	hps@act.gov.au

HOLDER ACT 2611	WESTON CREEK ACT 2611

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 Qualifications: Copy of training certificate and results attached
☐	Declaration signed (page 5)

PART A – APPLICANT DETAILS

TITLE (Mr, Ms)	GIVEN NAMES	FAMILY NAME

PRIMARY PRACTICE NAME

PRIMARY PRACTICE ADDRESS *(Property Name, Unit, Flat Number, Street Number, Street Name)*

CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE

PRIMARY PRACTICE POSTAL ADDRESS *(If different to above practice address)*

CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE

HOME TELEPHONE NUMBER	MOBILE NUMBER

WORK TELEPHONE 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: / /

PART B – PROOF OF IDENTIFICATION ***(must be completed for company (by the registered agent) or individual applicants)***

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.
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

FORM OF IDENTIFICATION PROVIDED

Type	Number	Expiry Date	Certified Copy Attached
			☐
			☐

PART C - QUALIFICATIONS

PLEASE INDICATE: ☐ Doctor ☐ Specialist

Specialty:_____

PRESCRIBER REGISTRATION No.

In accordance with the Medicines, Poisons and Therapeutic Goods (Guidelines for treatment of opioid dependency) Approval 2018 (No 1), prescribers wishing to become endorsed must undertake training provided by ACT Health.

TRAINING/EXAMINATION/PLACEMENT COMPLETED

Applicants must provide a copy of training attendance certificate and exam results with their application.

☐ ACT Health Alcohol and Drug Services Training ***and/or*** ☐ NSW Opioid Treatment Accreditation Course	Date Attended: / / Date Attended: / /
☐ NSW Opioid Treatment Accreditation Course Examination	Date Completed: / /

Other relevant qualifications/training to treat drug-dependency?

Other relevant experience in treating drug-dependency?

ENDORSEMENT DURATION

Please tick (✓) ☐ 1 year ☐ 2 years ☐ 3 years

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 endorsement 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:**_____