ACT Government | ACT Health

HEALTH CARE FACILITY NEW LICENCE APPLICATION

PURPOSE

This form is to be used to apply for a licence under the *Public Health Act 1997* (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

Licence is issued to the applicant for the Health Care Facility licence, who is the person(s) who will have the overall responsibility for the Health Care Facility, including responsibility for any contraventions of the Act.
Accordingly:

(1) Trusts will not be registered. Companies operating as trustees for a trust will be registered in the Company name only.

(2) Applications listing a partnership as the Applicant will not be accepted. If your business is operated by a partnership, one or more of the individuals in the partnership will need to be listed.

(3) Parts B and C of this application form must be completed separately by each individual listed as an applicant. Extra copies of Parts B and C are available at www.health.act.gov.au/hps or by contacting the HPS.

- A floor plan showing the layout of all fixtures and fittings of the premises must accompany this application. Plans may also be submitted electronically to hps@act.gov.au.
- Complete this form using a black or blue pen and return with the relevant fee (see page 7).
- Declaration on page 6 must be signed.

Is the licence to be issued to a Corporation (a Company, Incorporated Association, Government agency or a Registered Charitable Organisation)?

☐ **YES Complete PARTS A, C and D** *of this application. NB: Trusts or Partnerships will not be registered. Companies operating as trustees for a trust will be registered in the Company name only.*

☐ **NO Complete PARTS B, C and D** *of this application. Separate details must be completed for each individual listed as an owner.*

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 AND PAYMENT TO BE RETURNED

In Person:
Health Protection Service
25 Mulley Street
HOLDER ACT 2611

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

By Fax:
02 5124 5554

By Email:
hps@act.gov.au

If the application is faxed or emailed, please do not post the original.

CHECKLIST

If applying as an INDIVIDUAL	
☐	Part B completed and signed: Ownership details for an individual (one copy for each owner)
☐	Part C complete: Proof of identification (one copy for each owner)
☐	One form of current photographic identification (for each signatory) presented in person at the Health Protection Service **OR** One form of current photographic identification (for each signatory) sighted and certified by an authorised witness for each signatory.
☐	Part D completed: Particulars of business
☐	Attached detailed copies of plan **OR** Plans previously submitted for assessment
☐	Declaration signed (page 6)
☐	Attached payment (page 7)
If applying as a CORPORATION	
☐	Part A completed and signed: Ownership details of a company
☐	Attached current company extract issued by the Australian Securities and Investment Commission (ASIC)
☐	Part C complete: Proof of identification (for company agent)
☐	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 D completed: Particulars of business.
☐	Attached detailed copies of plan **OR** Plans previously submitted for assessment
☐	Declaration signed (page 6)
☐	Attached payment (page 7)

PART A – APPLICANT DETAILS FOR A COMPANY *(Do NOT complete if you are applying as an individual)*
A copy of the Company's current extract *(issued within the previous 30 days)* from the Australian Securities and Investment Commission (ASIC) must be attached.
COMPANY NAME
AUSTRALIAN COMPANY NUMBER (A.C.N.) - Leave blank if an Incorporated Association, Government agency or a Registered Charitable Organisation

PART B – APPLICANT DETAILS FOR AN INDIVIDUAL *(Do NOT complete if you are applying as a company)*		
Note for Multiple Owners: *(for example partnerships) Copies of Part B are available at www.health.act.gov.au/hps or by contacting the HPS.*		
TITLE (Mr, Ms)	**GIVEN NAMES**	**FAMILY NAME**

PART C - APPLICANT ADDRESS (If applying as a company the registered company address must be provided) *(Property Name, Unit, Flat Number, Street Number, Street Name)*		
CITY / SUBURB / TOWN	**STATE / TERRITORY**	**POSTCODE**

PART C - APPLICANT POSTAL ADDRESS *(If different to above applicant address)*		
CITY / SUBURB / TOWN	**STATE / TERRITORY**	**POSTCODE**

BUSINESS HOURS PHONE NUMBER	**MOBILE NUMBER**
FAX NUMBER	**EMAIL ADDRESS**

DECLARATION

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 : _____
(For Companies - Signature of authorised agent only)

Position Title (Companies):_____

Date: / /

PART C – PROOF OF IDENTIFICATION ***(Must be completed for company (by registered agent) and individual applicants)***

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

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
			☐
			☐

Note for Multiple Owners: *(for example partnerships) Copies of Part C are available at www.health.act.gov.au/hps or by contacting the HPS.*

PART D - PARTICULARS OF BUSINESS *(Must be completed)*

TRADING NAME		
PHYSICAL ADDRESS OF BUSINESS		
PROPERTY NAME:		
STREET ADDRESS:		
SUBURB:	**STATE:**	**POSTCODE:**

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

BUSINESS CORRESPONDENCE POSTAL ADDRESS		
NUMBER:	**STREET NAME:**	
SUBURB:	**STATE:**	**POSTCODE:**

HEALTH CARE FACILITIES DETAILS

Please indicate all procedures which will be undertaken within the facility in relation to which licence coverage is sought:

Administration of a general anaesthetic	☐ Yes	☐ No
Spinal anaesthetic	☐ Yes	☐ No
Epidural anaesthetic	☐ Yes	☐ No
Major regional block anaesthetic not including mandibular blocks	☐ Yes	☐ No
Intravenous sedative	☐ Yes	☐ No
Endoscopy	☐ Yes	☐ No
Dialysis, haemofiltration or haemoperfusion	☐ Yes	☐ No
Prolonged intravenous infusion of a single cytotoxic agent or sequential intravenous infusion of more than one cytotoxic agent	☐ Yes	☐ No
Cardiac catheterisation	☐ Yes	☐ No

Number of patient beds in facility: _____

Are overnight patient stays provided on the facility's premises? ☐ Yes ☐ No

Does the facility hold Accreditation? ☐ Yes ☐ No *If yes,* **Expiry Date:**_____

If Yes please enter accrediting agency details: **Name**:_____

Is the sterilisation of surgical equipment completed on site? ☐ Yes ☐ No

If Yes please provide details of person/company responsible for sterilisation:

Name:_____ **Phone:**_____ **Fax:**_____

Company (if applicable): _____

Does the facility employ a person responsible for Infection Control? ☐ Yes ☐ No

If Yes please provide person's details: **Name:**_____ **Phone:**_____

Percentage of time dedicated to infection control: _____%

Does the facility have an Infection Control Policy and Procedures Manual? ☐ Yes ☐ No

When was the facility procedures manual last updated/reviewed? _____/_____/_____

Is patient food prepared at the facility? ☐ Yes ☐ No *If Yes please provide Food Business Registration No.*_____

Please provide details of person/company responsible for preparation of patient food:

Name:_____ **Phone:**_____ **Fax:**_____

Company (if applicable): _____

Please provide person/company details of responsible party for the removal of clinical waste from the facility:

Name:_____ **Phone:**_____ **Fax:**_____

Company (if applicable): _____ **ABN:**_____

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:**_____

PAYMENT

LICENCE DURATION AND HEALTH CARE FACILITY TYPE – PLEASE TICK (✓)							
Accredited Health Care Facility <200 beds		**Accredited Health Care Facility >200 beds**		**Non Accredited Health Care Facility**		**Health Care Facility – Sole Dentist**	
	Fee		**Fee**		**Fee**		**Fee**
☐ **1 Year**	$676	☐ **1 Year**	$1350	☐ **1 Year**	$1010	☐ **1 Year**	$270
☐ **2 Years**	$1352	☐ **2 Years**	$2700	☐ **2 Years**	$2020	☐ **2 Years**	$540
☐ **3 Years**	$2028	☐ **3 Years**	$4050	☐ **3 Years**	$3030	☐ **3 Years**	$810
Please complete payment details below.							

PAYMENT METHOD

Please tick (✓)

☐ Cash

☐ Cheque (please make payable to the Health Protection Service)

☐ Credit card (please complete details below)

CREDIT CARD DETAILS - IF PAYING BY CREDIT CARD

☐ I agree to this credit card being debited the required fee and the credit card details being destroyed once the transaction is processed.

GST is not applicable under section 81-5 of the A New Tax System (Goods and Services Tax) Act 1999.

Card Holder's Name: _____

Card Holder's Signature: _____ Date: _____/_____/_____

Daytime Phone No: _____

Card Number (Visa or MasterCard only) **Expiry Date**

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐/☐☐