ACT Government | ACT Health

HEALTH CARE FACILITY LICENCE VARIATION

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

- If you are changing location or the licensee details this variation form cannot be used. A Transfer or New Application form must be completed and submitted to the Health Protection Service.
- This application form must be signed by the licensee and the original licence certificate (or a copy) must be attached to this application.
- Complete this form using a black or blue pen only.

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 ***If the application is faxed or emailed please do not post the original.***	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 variations you are applying for and ONLY complete the sections relevant to your changes.
☐ Trading Name ☐ Contact Details ☐ Postal Details ☐ Facility Details

VARIATION IN TRADING NAME
NEW TRADING NAME:

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

POSTAL DETAILS – BUSINESS CORRESPONDENCE POSTAL ADDRESS		
STREET NUMBER/PO BOX:	**STREET NAME:**	
SUBURB:	**STATE:**	**POSTCODE:**

FACILITY DETAILS

Have you changed the number of patient beds in the facility? ☐ Yes ***(please specify the changes below)*** ☐ No

New number of beds in the facility:__________

Have you changed the accreditation status of the facility? ☐ Yes ***(please specify the changes below)*** ☐ No

Name:____ **Expiry Date:_____________________________________**

Has the facility lost accreditation since initial application? ☐ Yes ☐ No

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

Has the facility changed the person/company responsible for the sterilisation of surgical equipment?

☐ Yes ***(please specify the changes below)*** ☐ No

Name of company/person responsible:____

Phone:_________________________ **Fax:_______________________** **ABN:_______________________________________**

Has the employee responsible for Infection Control for the facility changed?

☐ Yes ***(please specify their details below)*** ☐ No

Name:____ **Phone:____**

Fax:________________________________ **Email:____**

FACILITY DETAILS - *Continued*
Has the person/company responsible for patient food preparation at the facility changed? ☐ Yes ☐ No *If Yes, please provide the new Food Business Registration No.:*___________________ *Please provide details of person/company responsible for preparation of patient food:* **Name:**____________________________________ **Phone:**_____________________ **Fax:**________________________ **Company (if applicable):** ____
Has the person/company responsible for the removal of clinical waste from the facility changed? ☐ Yes ***(please specify their detailsbelow)*** ☐ No **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 variation 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:**____