ACT Government

ACT Health

MEDICINES POISONS & THERAPEUTIC GOODS APPLICATION TO AMEND LICENCE

PURPOSE

This form is to be used to apply for an amendment to a licence under the *Medicines, Poisons and Therapeutic Goods Act 2008* (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 form.
- You cannot amend the licence holder with this form. A new application must be submitted.
- Complete this form using a black or blue pen only and return with the **fee.**
- This form may be used to amend the following licence types:
  - First Aid Kit Licence
  - Research & Education Program Licence
  - Medicines Wholesalers Licence
  - Pharmacy Medicines Rural Committees Licence
  - Dangerous Poisons Manufacturers Licence
  - Dangerous Poisons Suppliers Licence

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/permit certificate)*		

PARTICULARS OF BUSINESS AMENDMENT ***(Must be completed)***

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

☐ Business Details	☐ Contact Details	☐ Postal Details	☐ Authorised Substance
☐ Authorised Person	☐ Details of Use	☐ Supervisor	☐ Researcher Details
☐ Details of Program	☐ Security Arrangements		

BUSINESS DETAILS		
NEW TRADING NAME:		
PHYSICAL ADDRESS OF BUSINESS		
SHOP NUMBER:	**PROPERTY NAME:**	
STREET ADDRESS:		
SUBURB:	**STATE:**	**POSTCODE:**

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:**

AUTHORISED SUBSTANCE

SUBSTANCE DETAILS:

NAME OF SUBSTANCE	STRENGTH	FORM OF SUBSTANCE	MAXIMUM QUANTITY*	TOTAL QUANTITY*

***** *Maximum Quantity:* the quantity that would be possessed under the licence at any one time.

***** *Total Quantity:* the quantity that may be possessed during the licence period.

PARTICULARS OF BUSINESS AMENDMENT *(CONTINUED)*
SECURITY ARRANGEMENTS
Please provide details:

AUTHORISED PERSON DETAILS - *Applicable to First Aid Kit licence <u>ONLY</u>*

Details of each additional person proposed to be authorised to deal under the licence.
If insufficient space provided to record all details, please attach additional information to this application.
<u>Note:</u> Occupation must be a registered nurse or ambulance paramedic.
Ambulance paramedic qualifications must be an Associate Diploma Health Science (Ambulance Officer) or equivalent.

Given Names	**Family Name**	**Residential Address**	**Occupation**	**Qualifications & Board Registration No.** (*if applicable*)

DETAILS OF USE - *Applicable to First Aid Kit licence <u>ONLY</u>*

Details of the situations in which the proposed medicines will be used (e.g. operational protocols).
Details of workplaces and/or community venues at which the relevant medicines are proposed to be administered.

SUPERVISOR – *Applicable to Research & Education, Medicines Wholesalers and Dangerous Poisons licences <u>ONLY</u>*	
GIVEN NAME:	**FAMILY NAME:**
BUSINESS NUMBER:	**MOBILE:**
QUALIFICATIONS*:	

<u>Supervisor Qualifications</u>, for Research and Education Program, refer to academic, professional or other relevant experience.

PARTICULARS OF BUSINESS AMENDMENT *(CONTINUED)*	
RESEARCHER DETAILS - *Applicable to Research and Education Program licences ONLY*	
GIVEN NAME:	**FAMILY NAME:**
BUSINESS NUMBER:	**MOBILE:**
QUALIFICATIONS*:	

***Researcher Qualifications**: for Research and Education Program, researchers refer to academic, professional or other relevant experience.*

DETAILS OF PROGRAM - *Applicable to Research and Education Program licence ONLY*
PROGRAM/PROJECT TITLE:

DESCRIPTION OF THE PROGRAM/PROJECT: *(include an explanation of why it cannot be carried out satisfactorily without the use of the proposed regulated substance(s):*

DECLARATION – *Applicable to all licences*

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:** _____

CREDIT CARD DECLARATION - IF PAYING BY CREDIT CARD

☐ I agree to the credit card (details provided at **Part K**) being debited the required fee and credit card details destroyed immediately once the transaction is processed.

SIGNATURE: _____ **DATE:**_____

PART K - PAYMENT

How to Pay

Fax: 5124 5554
MasterCard / Visa accepted
(Not accepted where plans are involved)

By Mail: Health Protection Service
Locked Bag 5005 Weston Creek ACT 2611.

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

Please Note:

1. All paperwork must be completed and signed.
2. Where plans are involved, the originals must be received prior to the granting of your licence/registration certificate.
3. Applications sent by fax should **NOT** also be mailed.

Payment Method

Please Tick (ü)

☐ **Cheque** ☐ **Credit Card**

Note: Cheque should be made payable to the Health Protection Service.

Contact Person: _____

Type of Credit Card - Please Tick (ü) ☐ Visa ☐ Master Card

Credit Card No **Expiry Date**

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐/☐☐

Fee $44.00

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

I agree that the Health Protection Service debit my account the above fee.

Card Holders' Name: _____

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

Daytime Phone No: _____