

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: www.health.act.gov.au/hps	General Enquires: (02) 5124 9700	Email Address: hps@act.gov.au	Fax Number: (02) 5124 5554
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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: Health Protection Service Howard Florey Centenary House 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
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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 NAMENEW 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) <i>(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.)</i>
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REQUIRED INFORMATION

Are all beneficiaries the same as the shareholders? Yes No

If YES please proceed to the declaration section on page 5. If NO 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