

PUBLIC EMPLOYEES PERMIT NEW APPLICATION

PURPOSE

This form is to be used to apply for a permit under the *Medicines, Poisons and Therapeutic Goods Act 2008*.
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 permit 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 Enquiries:

(02) 5124 9700

Email Address:

hps@act.gov.au

Fax Number:

(02) 5124 5554

INSTRUCTIONS FOR COMPLETION & IMPORTANT INFORMATION

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

Accordingly; person(s) may be listed on the permit by individual name or public employee position number.

- **There is no Fee Required.**
- The applicant should be familiar with the *Medicines, Poisons and Therapeutic Goods Act 2008* and the *Medicines, Poisons and Therapeutic Goods Regulation 2008*.
- Failure to comply with ACT legislation renders a person liable to prosecution.
- Information is collected for permit purposes and will not be provided to other parties without consent or unless otherwise required by law.
- Complete this form using a black or blue pen only.

Confirmation of identity will need to be produced either:

1. In person at the Health Protection Service office; or
2. By submitting photographic 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:

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

PART A – APPLICANT DETAILS

TITLE <i>(Mr, Ms)</i>	GIVEN NAME	FAMILY NAME	
POSITION TITLE		POSITION NUMBER	
APPLICANT RESIDENTIAL ADDRESS <i>(Property Name, Unit, Flat Number, Street Number, Street Name)</i>			
CITY / SUBURB / TOWN		STATE / TERRITORY	POSTCODE
POSTAL ADDRESS <i>(If different to above address)</i>			
CITY/ SUBURB/ TOWN		STATE / TERRITORY	POSTCODE
HOME TELEPHONE NUMBER		MOBILE TELEPHONE NUMBER	
WORK TELEPHONE NUMBER		EMAIL ADDRESS	

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: _____

Position title: _____

Date: / /

Note for Multiple Applicants:

Copies of Part B are available at www.health.act.gov.au/hps or by contacting the HPS.

PART B – PROOF OF IDENTIFICATION

One form of current photographic identification must be provided for each signatory in Part A.

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	Copy Attached
			<input type="checkbox"/>
			<input type="checkbox"/>

PART C – PERMIT APPLICATION DETAILS – (Must be completed)

PERMIT

REQUIRED INFORMATION – Attached to application

Authorised Person’s Details: Duty statement(s) for authorised person(s) if listed by position no.

Declaration on page 6 signed.

AGENCY, DEPARTMENT, BRANCH OR SECTION OFFICE NAME – if applicable

PHYSICAL ADDRESS OF AGENCY, DEPARTMENT, BRANCH OR SECTION OFFICE

NUMBER: PROPERTY NAME:

STREET NAME:

SUBURB: STATE: POSTCODE:

OFFICE ONSITE CONTACT PERSON

GIVEN NAME: FAMILY NAME:

BUSINESS PHONE: MOBILE PHONE:

EMAIL ADDRESS: FAX:

APPLICANT’S PROFESSIONAL DETAILS (if applicable)

OCCUPATION:

REGISTRATION BOARD NO:

Is the storage address the same as physical address of office? No Yes (If Yes continue to OPERATIONAL DETAILS)

PROGRAM/STORAGE ADDRESS

SHOP NUMBER: PROPERTY NAME:

STREET NAME:

SUBURB: STATE: POSTCODE:

CONTACT NAME: CONTACT NUMBER:

OPERATIONAL DETAILS (applicable to all permits)

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.

ADDITIONAL AUTHORISED PERSON DETAILS <i>(if applicable)</i>				
<p><i>Details of each other person proposed to be authorised to deal under the permit.</i></p> <p><i>If insufficient space provided to record all details, please attach additional information to this application.</i></p> <p><i>Person(s) may be listed on the permit by individual name or public employee position number.</i></p> <p>Do you wish for authorised person(s) to be listed on permit by <input type="checkbox"/> Name or <input type="checkbox"/> Position Number</p>				
GIVEN NAMES	FAMILY NAME	POSITION TITLE	POSITION NUMBER	OCCUPATION

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

If insufficient space provided to record all details, please attach additional information to this application.

SECURITY ARRANGEMENTS

Provide information

DURATION OF PERMIT

Please select desired duration of Permit:

- 1 Year - 2 Years - 3 Years

Please ensure both declarations below are signed before submitting form

DECLARATION OF SUITABILITY

I declare that I am a suitable person to hold a permit because:

- I, a close associate or a corporation where I am an executive officer, has not been convicted or found guilty in the 5-year period before the day of application for the licence of an offence against this Act or an offence in Australia or elsewhere in relation to a regulated substance or regulated therapeutic good.
- I, or a close associate, are not an undischarged bankrupt now or were in the 5-year period before application, or have executed a personal insolvency agreement.
- I, or a close associate, were not involved in the management of a corporation in the 5-year period before application that became the subject of a winding-up order or an administrator was appointed for the corporation

NAME:

SIGNATURE:

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: _____