ACT Government

ACT Health

COMMUNITY PHARMACY 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

A Licence is issued to the owner of the pharmacy, who is the person(s) who will have the overall responsibility for the business, including responsibility for any contraventions of the Act.
Accordingly:

(1) Trusts will not be licensed. Companies operating as trustees for a trust will be licensed, in the company name only.

(2) Applications listing a partnership as the owner will not be accepted. If your business is operated by a partnership, all individuals in the partnership must be listed.

- Under the Act, a floor plan showing the layout of all fixtures and fittings of the premises must accompany this application.
- A corporation must comply with requirements outlined in section 66V of the *Public Health Act 1997* in order for it to be deemed a complying pharmacy corporation.
- Complete this form using a black or blue pen only and return with the required fee (see page 9).
- Declaration on page 8 must be signed.
  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).

Is the licence to be issued to a Complying Pharmacy Corporation?

☐ **YES *Complying Pharmacy Corporation* - Complete PART A SECTIONS 1, 2, 3, (4 if required), C, D and payment** *of this application. NB: Trusts or partnerships will not be licensed. Companies operating as trustees for a trust will be licensed in the company name only.*

☐ **NO *Pharmacist (Sole Trader/Partnership)* - Complete PART B for all applicable owners, C, D and payment** *of this application. Separate details must be completed by each individual owner of a partnership.*

Confirmation of identity will need to be produced either:

1. **In person at the Health Protection Service offices; or**
2. **By submitting 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.

PART A – SECTION 1 COMPLYING PHARMACY CORPORATION DETAILS

COMPANY NAME

AUSTRALIAN COMPANY NUMBER (A.C.N.)
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.

REGISTERED COMPANY ADDRESS *(Property name, Unit, Flat Number, Street Number, Street name)*

CITY / SUBURB / TOWN	**STATE / TERRITORY**	**POSTCODE**

REQUIRED INFORMATION *(must be provided with application)*	
Have you attached a copy of the pharmacy corporation's constitution?	☐ **YES**
Have you attached a copy of the current ASIC company extract (issued within the previous 30 days) outlining directors and shareholders for the pharmacy corporation?	☐ **YES**
Is the trust deed for a pharmacy corporation that acts as a trustee for a trust attached?	☐ **YES** ☐ **N/A**
If a shareholder and/or trust beneficiary is a close relative to a pharmacist director/shareholder, have you provided evidence to support this relationship to the applicant?	☐ **YES** ☐ **N/A**

COMPANY DECLARATION

I, _____, confirm that the information supplied in this Part is true and accurate and understand that the provision of false or misleading information is an offence.

Signature: _____ Date: / /

Position Title:_____

PART A – SECTION 2 – DIRECTOR DETAILS *(only a pharmacist may be a director of a complying pharmacy corporation)*

Director 1
Name:
Pharmacist registration number (PHA):

Director 2
Name:
Pharmacist registration number (PHA):

Director 3
Name:
Pharmacist registration number (PHA):

Director 4
Name:
Pharmacist registration number (PHA):

Director 5
Name:
Pharmacist registration number (PHA):

Director 6
Name:
Pharmacist registration number (PHA):

If more than 6 directors, you must attach information separately.

PART A – SECTION 3 – SHAREHOLDER DETAILS *(A shareholder in a complying pharmacy corporation must be either a pharmacist or a close relative of a pharmacist shareholder)*

Shareholder 1
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Shareholder 2
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Shareholder 3
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Shareholder 4
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Shareholder 5
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Shareholder 6
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

If more than 6 shareholders, you must attach information separately.

PART A – SECTION 4 – TRUST BENEFICIARY DETAILS *(If applicable)*

(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.)

Are all beneficiaries the same as the shareholders? ☐ **No** ***(list all trust beneficiaries below)***
☐ **Yes** ***(proceed to PART D – Pharmacy Particulars)***

TRUST NAME

TRUSTEES
Name:
Name:
Name

If more than three (3) Trustees, you must attach information separately.

Trust Beneficiary 1
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Trust Beneficiary 2
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Trust Beneficiary 3
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Trust Beneficiary 4
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Trust Beneficiary 5
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

Trust Beneficiary 6
Name:
Pharmacist registration number (PHA) or relationship to pharmacist:

If more than 6 Trust Beneficiaries, you must attach information separately.

PART B – DETAILS FOR INDIVIDUAL OWNER OR PARTNERSHIP *(Pharmacist – Sole Trader/Partnership)*

Owner 1
Name:
Pharmacist Registration Number:
DECLARATION
I, _____, confirm that the information supplied in this Part is true and accurate and understand that the provision of false or misleading information is an offence. Signature: _____ Date: / / Title: _____

Owner 2
Name:
Pharmacist Registration Number:
DECLARATION
I, _____, confirm that the information supplied in this Part is true and accurate and understand that the provision of false or misleading information is an offence. Signature: _____ Date: / / Title: _____

Owner 3
Name:
Pharmacist Registration Number:
DECLARATION
I, _____, confirm that the information supplied in this Part is true and accurate and understand that the provision of false or misleading information is an offence. Signature: _____ Date: / / Title: _____

PART B – DETAILS FOR INDIVIDUAL OWNER OR PARTNERSHIP *(Pharmacist – Sole Trader/Partnership)*

Owner 4
Name:
Pharmacist Registration Number:
DECLARATION
I, _____, confirm that the information supplied in this Part is true and accurate and understand that the provision of false or misleading information is an offence. Signature: _____ Date: / / Title: _____

Owner 5
Name:
Pharmacist Registration Number:
DECLARATION
I, _____, confirm that the information supplied in this Part is true and accurate and understand that the provision of false or misleading information is an offence. Signature: _____ Date: / / Title: _____

Owner 6
Name:
Pharmacist Registration Number:
DECLARATION
I, _____, confirm that the information supplied in this Part is true and accurate and understand that the provision of false or misleading information is an offence. Signature: _____ Date: / / Title: _____

Note for Multiple Owners: *If more than 6 owners, copies of Part B are available at* www.health.act.gov.au/hps *or by contacting the Health Protection Service.*

PARTNERSHIP DETAILS (for businesses operated by partnership only)
Name of Partnership:
If the applicants operate as a partnership (that is, an association of 2 or more people who carry on a business and distribute profits or losses between themselves) you must include with this application a copy of the partnership agreement or, if not in printed form, the details of the arrangement including the identity of each partner and a description of their interest in the partnership and the rights, obligations and liabilities of each partner. Partnership documentation attached: ☐ Yes ☐ N/A

PART C – PROOF OF IDENTIFICATION *(Must be completed for all company directors or individual owners)*

One form of current photographic identification must be provided for each signatory in Parts A or B.

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
			☐
			☐
			☐
			☐
			☐
			☐

Note for Multiple Owners or Directors: *Copies of Part C are available at www.health.act.gov.au/hps or by contacting the Health Protection Service.*

PART D – PARTICULARS OF PHARMACY

TRADING NAME

PHYSICAL ADDRESS OF PHARMACY		
SHOP NUMBER:	**PROPERTY NAME:**	
STREET NAME:		
SUBURB:	**STATE:**	**POSTCODE:**
PHARMACY PH:	**PHARMACY FAX:**	**EMAIL:**

PLAN SUBMISSION ***(please tick below the one that applies)***
Plans can be submitted to hps@act.gov.au in maximum A3 size

- ☐ Detailed copies of plans for the new business are attached.
- ☐ Plans of the new premises were previously submitted for assessment on ____ / ____ / _____

CONTACT PERSON ***(for all enquires or correspondence. MUST be one of the applicants from Part A or B)***	
GIVEN NAME:	**FAMILY NAME:**
PHONE NUMBER:	**MOBILE PHONE:**
AFTER HOURS PHONE:	**FAX:**
EMAIL ADDRESS:	
LIKELY HOURS OF TRADE: Days/Open/Close Times:	
BUSINESS CORRESPONDENCE POSTAL ADDRESS:	
ROOM/ SHOP NUMBER/PO BOX:	**PROPERTY NAME:**
STREET NAME:	
SUBURB:	**STATE:** **POSTCODE:**

DECLARATION – ***(Must be completed by all company directors and / or individual owners)***

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 owners or directors, you must attach signatures separately

PAYMENT

LICENCE DURATION

Please tick (✓) your desired duration

- ☐ 1 Year (fee $ 698.25)
- ☐ 2 Years (fee $ 1,396.50)
- ☐ 3 Years (fee $ 2,094.75)

Please complete Payment Method below.

PAYMENT METHOD

Please tick (✓)

- ☐ 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**

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐/☐☐