



OPIOID DEPENDENCY TREATMENT CENTRE LICENCE (PHARMACIST) APPLICATION

PURPOSE

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

www.health.act.gov.au/hps

General Enquires:

(02) 6205 1700

Email Address:

hps@act.gov.au

Fax Number:

(02) 6205 1705

INSTRUCTIONS FOR COMPLETION & IMPORTANT INFORMATION

- **No fee is required.**
- The applicant should be familiar with the *Medicines, Poisons and Therapeutic Goods Act 2008* and Regulation 2008, the National Guidelines for Medication-Assisted Treatment of Opioid Dependence (2014) and the Opioid Maintenance in the ACT: Local Policies and Procedures.
- The applicant should also be familiar with training requirements that are outlined in the Medicines, Poisons and Therapeutic Goods (Guidelines for treatment of opioid dependency) Approval 2018 (No 1).
- Failure to comply with ACT legislation renders a person liable to prosecution.
- Information is collected for licence purposes and will not be provided to other parties without consent or unless otherwise required by law.
- The applicant must be a pharmacist at a community pharmacy.
- 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 certified 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) 6205 1705



By Email:

hps@act.gov.au

CHECKLIST

<input type="checkbox"/>	Part A completed and signed: Applicant Details
<input type="checkbox"/>	Part B complete: Proof of identification
<input type="checkbox"/>	One form of current photographic identification presented in person at the Health Protection Service OR One form of current photographic identification sighted and certified by an authorised witness
<input type="checkbox"/>	Part C Licence application details: Copy of training certificate attached
<input type="checkbox"/>	Declaration of suitability signed (page 6)
<input type="checkbox"/>	Declaration signed (page 6)

PART A – APPLICANT DETAILS

TITLE (Mr, Ms, Dr, Prof)	GIVEN NAMES	FAMILY NAME
APPLICANT RESIDENTIAL ADDRESS (Property Name, Unit, Flat Number, Street Number, Street Name)		
CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE
POSTAL ADDRESS (If different to above company address)		
CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE
HOME TELEPHONE NUMBER	MOBILE NUMBER	
WORK NUMBER	EMAIL ADDRESS	
AUSTRALIAN BUSINESS NUMBER (A.B.N) (if applicable)		

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: _____

Date: / /

Note for Multiple Applicants:
 (for example partnerships) 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 sighted and certified by an authorised witness must be provided for each signatory in Part A

A list of authorised witnesses for true and correct copy can be found at:
<http://www.ag.gov.au/Publications/Pages/Statutorydeclarationsignatorylist.aspx>

The witness should include the following text on a certified copy:

EXAMPLE

CERTIFIED TRUE COPY OF THE ORIGINAL
 I certify that this is a true and accurate copy of the original document sighted by me.
 Full Name: _____ Signed: _____ Dated: _____ Authority to sign: _____ Phone: _____

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

PART C – LICENCE APPLICATION DETAILS – (must be completed)

TRADING NAME – <i>If applicable</i>		
PHYSICAL ADDRESS OF BUSINESS		
NUMBER:	PROPERTY NAME:	
STREET NAME:		
SUBURB:	STATE:	POSTCODE:
COMMUNITY PHARMACY LICENCE NUMBER:		

BUSINESS ONSITE CONTACT PERSON		
GIVEN NAME:	FAMILY NAME:	
BUSINESS PHONE:	MOBILE PHONE:	
EMAIL ADDRESS:	FAX:	

APPLICANT’S PROFESSIONAL DETAILS <i>(if applicable)</i>
OCCUPATION:
PHARMACIST REGISTRATION NUMBER:

APPLICANT TRAINING IN OPIOID DEPENDENCY TREATMENT
APPLICANT HAS COMPLETED REQUIRED TRAINING COURSE: <input type="checkbox"/> Yes <input type="checkbox"/> No
COPY OF TRAINING CERTIFICATE ATTACHED: <input type="checkbox"/> Yes <input type="checkbox"/> No

Is the address for storage of methadone and buprenorphine the same as the physical address of the business?

No Yes *If **Yes** continue to SECURITY ARRANGEMENTS; If **No**, provide storage address below then detail security arrangements*

STORAGE ADDRESS		
NUMBER:	PROPERTY NAME:	
STREET NAME:		
SUBURB:	STATE:	POSTCODE:
CONTACT NAME:	CONTACT NUMBER:	

SECURITY ARRANGEMENTS
<i>Please provide details.</i>

Please ensure both declarations on page 6 are signed before submitting form.

DURATION OF LICENCE

Please select desired duration of licence:

- 1 Year

- 2 Years

- 3 Years

Please ensure both declaration sections below are signed before submitting form.

DECLARATION OF SUITABILITY

I declare that I am a suitable person to hold a licence 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 the 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:
