ACT Health

COMMUNITY PHARMACY APPLICATION TO TRANSFER LICENCE

PURPOSE

This form is to be used to apply for a transfer to a licence holder 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:	**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 current licensee(s) and new applicant(s).
- The original licence certificate must be attached to this application.
- All associated documentation 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 a **fee of $374**.
  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).

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 licenced. Companies operating as trustees for a trust will be licensed, but 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 of the individuals in the partnership will need to be listed.

Is the **current** licence issued to a:

☐ **Pharmacist (Sole Trader/Partnership)** — Current owner(s) to complete Parts A, B, C & E

☐ **Complying Pharmacy Corporation** — Current owner(s) to complete Parts A, B, D & E

Is the **new** licence to be issued to a:

☐ **Pharmacist (Sole Trader/Partnership)** — New owner(s) to complete Parts F, G, H, I & K

☐ **Complying Pharmacy Corporation** — New owner(s) to complete Parts F, G, H, J *[pg 11 – 15]* & Part K

Confirmation of identity will need to be produced either:

1. **In person at the Health Protection Service office; or**
2. **By Certified copies submitted by 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:	**By Post:**	**By Fax:**	**By Email:**
ealth 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

PART A - REQUIRED INFORMATION *(must be completed)*		
LICENCE NUMBER:	**FILE NUMBER:**	**EXPIRY DATE:**
TRADING NAME: *(As appears on current licence certificate)*		

PART B - CURRENT OWNERSHIP TYPE – *Must be completed by all current owners*

Tick both boxes if both apply

☐ **Pharmacist (Sole Trader/Partnership)** - Please fill out Current Owner Details and Declaration

☐ **Complying Pharmacy Corporation** - Please fill out Current Complying Corporation and Current Director Details

PART C - CURRENT OWNER DETAILS – *(Pharmacist – Sole Trader/Partnership)*
Current Owner 1
Family Name:
Given Name:
Pharmacist registration number (PHA):

Current Owner 2
Family Name:
Given Name:
Pharmacist registration number (PHA):

Current Owner 3
Family Name:
Given Name:
Pharmacist registration number (PHA):

Current Owner 4
Family Name:
Given Name:
Pharmacist registration number (PHA):

Current Owner 5
Family Name:
Given Name:
Pharmacist registration number (PHA):

Current Owner 6
Family Name:
Given Name:
Pharmacist registration number (PHA):

Note for multiple owners: if more than six owners, you must attach separate copies of Part C

PART D - CURRENT COMPLYING PHARMACY CORPORATION – *(Corporation details)*	
Company Name:	
ACN:	**ABN:**

CURRENT DIRECTOR DETAILS – *(Only a pharmacist may be a director of complying pharmacy corporations)*
Current Director 1
Family Name:
Given Name:
Pharmacist registration number (PHA):

Current Director 2
Family Name:
Given Name:
Pharmacist registration number (PHA):

Current Director 3
Family Name:
Given Name:
Pharmacist registration number (PHA):

Current Director 4
Family Name:
Given Name:
Pharmacist registration number (PHA):

Current Director 5
Family Name:
Given Name:
Pharmacist registration number (PHA):

Current Director 6
Family Name:
Given Name:
Pharmacist registration number (PHA):

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

THE DECLARATION ON THE FOLLOWING PAGE (p4) MUST BE SIGNED BY ALL CURRENT OWNERS/DIRECTORS

PART E - DECLARATION – *(Must be completed by all CURRENT owners/Directors)*			
I, the undersigned, understand my obligations as a licensee under the Public Health Act 1997. I declare that the proceeding 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

PART F - NEW OWNER DETAILS

PART G - BUSINESS DETAILS
NEW TRADING NAME *(if applicable)*:

PART H - CONTACT PERSON *(for all enquires or correspondence. MUST be one of the new applicants)*		
GIVEN NAME:	**FAMILY NAME:**	
PHONE NUMBER:	**MOBILE PHONE:**	
AFTER HOURS PHONE:	**FAX:**	
EMAIL ADDRESS:		
ROOM/ SHOP NUMBER/PO BOX:	**PROPERTY NAME:**	
STREET NAME:		
SUBURB:	**STATE:**	**POSTCODE:**
NEW OWNERSHIP TYPE – ***Must be completed by all new applicants***		

Tick both boxes if both apply

☐ **Pharmacist (Sole Trader/Partnership)** - Please fill out new Owner Details and Declaration for all owners (PART I)

☐ **Complying Pharmacy Corporation** - Please fill out new Complying Corporation and Current Director Details (PART J)

PART I - NEW INDIVIDUAL OWNER OR PARTNERSHIP DETAILS ***(Pharmacist – Sole Trader/Partnership)***

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 I - NEW INDIVIDUAL OWNER OR PARTNERSHIP DETAILS *(Pharmacist – Sole Trader/Partnership)*

NEW OWNER 1

TITLE *(Mr, Ms)*	**GIVEN NAMES**	**FAMILY NAME**

PHARMACIST REGISTRATION NUMBER (PHA)

PROPRIETOR RESIDENTIAL ADDRESS *(Property Name, Unit, Flat Number, Street Number, Street Name)*

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

POSTAL ADDRESS (*If different to above address*)

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

HOME TELEPHONE NUMBER	**MOBILE TELEPHONE NUMBER**
( )	
WORK TELEPHONE NUMBER	**EMAIL ADDRESS**
( )	

AUSTRALIAN BUSINESS NUMBER (A.B.N.) *(If applicable)*

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: *Additional owner forms are included in this application. Copies are available at* www.health.act.gov.au/hps *or by contacting the Health Protection Service.*

PART I - NEW INDIVIDUAL OWNER OR PARTNERSHIP DETAILS *(Pharmacist – Sole Trader/Partnership)*

NEW OWNER 2

TITLE *(Mr, Ms)*	**GIVEN NAMES**	**FAMILY NAME**

PHARMACIST REGISTRATION NUMBER (PHA)

PROPRIETOR RESIDENTIAL ADDRESS *(Property Name, Unit, Flat Number, Street Number, Street Name)*

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

POSTAL ADDRESS (*If different to above address*)

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

HOME TELEPHONE NUMBER	**MOBILE TELEPHONE NUMBER**
( )	
WORK TELEPHONE NUMBER	**EMAIL ADDRESS**
( )	

AUSTRALIAN BUSINESS NUMBER (A.B.N.) *(If applicable)*

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: *Additional owner forms are included in this application. Copies are available at* www.health.act.gov.au/hps *or by contacting the Health Protection Service.*

PART I - NEW INDIVIDUAL OWNER OR PARTNERSHIP DETAILS *(Pharmacist – Sole Trader/Partnership)*

NEW OWNER 3

TITLE *(Mr, Ms)*	GIVEN NAMES	FAMILY NAME

PHARMACIST REGISTRATION NUMBER (PHA)

PROPRIETOR RESIDENTIAL ADDRESS *(Property Name, Unit, Flat Number, Street Number, Street Name)*

CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE

POSTAL ADDRESS (*If different to above address*)

CITY/ SUBURB/ TOWN	STATE / TERRITORY	POSTCODE

HOME TELEPHONE NUMBER	MOBILE TELEPHONE NUMBER
( )	
WORK TELEPHONE NUMBER	**EMAIL ADDRESS**
( )	

AUSTRALIAN BUSINESS NUMBER (A.B.N.) *(If applicable)*													

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: *Additional owner forms are included in this application. Copies are available at* www.health.act.gov.au/hps *or by contacting the Health Protection Service.*

PART I - NEW INDIVIDUAL OWNER OR PARTNERSHIP DETAILS *(Pharmacist – Sole Trader/Partnership)*

NEW OWNER 4

TITLE *(Mr, Ms)*	GIVEN NAMES	FAMILY NAME

PHARMACIST REGISTRATION NUMBER (PHA)

PROPRIETOR RESIDENTIAL ADDRESS *(Property Name, Unit, Flat Number, Street Number, Street Name)*

CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE

POSTAL ADDRESS (*If different to above address*)

CITY/ SUBURB/ TOWN	STATE / TERRITORY	POSTCODE

HOME TELEPHONE NUMBER	MOBILE TELEPHONE NUMBER
( )	

WORK TELEPHONE NUMBER	EMAIL ADDRESS
( )	

AUSTRALIAN BUSINESS NUMBER (A.B.N.) *(If applicable)*													

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: *Additional owner forms are included in this application. Copies are available at* www.health.act.gov.au/hps *or by contacting the Health Protection Service.*

PART I - NEW INDIVIDUAL OWNER OR PARTNERSHIP DETAILS *(Pharmacist – Sole Trader/Partnership)*

NEW OWNER 5

TITLE *(Mr, Ms)*	GIVEN NAMES	FAMILY NAME

PHARMACIST REGISTRATION NUMBER (PHA)

PROPRIETOR RESIDENTIAL ADDRESS *(Property Name, Unit, Flat Number, Street Number, Street Name)*

CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE

POSTAL ADDRESS (*If different to above address*)

CITY/ SUBURB/ TOWN	STATE / TERRITORY	POSTCODE

HOME TELEPHONE NUMBER	MOBILE TELEPHONE NUMBER
( )	
WORK TELEPHONE NUMBER	**EMAIL ADDRESS**
( )	

AUSTRALIAN BUSINESS NUMBER (A.B.N.) *(If applicable)*														

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: *Additional owner forms are included in this application. Copies are available at* www.health.act.gov.au/hps *or by contacting the Health Protection Service.*

PART I - NEW INDIVIDUAL OWNER OR PARTNERSHIP DETAILS *(Pharmacist – Sole Trader/Partnership)*

NEW OWNER 6

TITLE *(Mr, Ms)*	GIVEN NAMES	FAMILY NAME

PHARMACIST REGISTRATION NUMBER (PHA)

PROPRIETOR RESIDENTIAL ADDRESS *(Property Name, Unit, Flat Number, Street Number, Street Name)*

CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE

POSTAL ADDRESS (*If different to above address*)

CITY/ SUBURB/ TOWN	STATE / TERRITORY	POSTCODE

HOME TELEPHONE NUMBER	MOBILE TELEPHONE NUMBER
( )	
WORK TELEPHONE NUMBER	**EMAIL ADDRESS**
( )	

AUSTRALIAN BUSINESS NUMBER (A.B.N.) *(If applicable)*													

PART J - 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: *Additional owner forms are included in this application. Copies of are available at* www.health.act.gov.au/hps *or by contacting the Health Protection Service.*

PART J - NEW COMPLYING PHARMACY CORPORATION DETAILS

COMPANY NAME		
AUSTRALIAN COMPANY NUMBER (A.C.N.) **The Company's current extract *(issued within the previous 30 days)* from the Australian Securities and Investment Commission**		
REGISTERED COMPANY 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**
TELEPHONE NUMBER	**MOBILE TELEPHONE NUMBER**	
( )		
WORK TELEPHONE NUMBER	**EMAIL ADDRESS**	
( )		

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

COMPANY DECLARATION

I, ____, confirm that the information supplied in the above part is true and accurate, and I understand that the provision of false or misleading information is an offence.

Signature: ____ Date: / /

Position Title:____

PROOF OF IDENTIFICATION ***(Must be completed for company directors and individual)***

One form of current photographic identification sighted and certified by an authorised witness' must be provided for each signatory.

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.
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
			☐
			☐
			☐
			☐
			☐
			☐

NEW DIRECTOR DETAILS *(only a pharmacist may be a director of a complying pharmacy corporation)*

New Director 1
Family Name:
Given Name:
Pharmacist registration number (PHA):

New Director 2
Family Name:
Given Name:
Pharmacist registration number (PHA):

New Director 3
Family Name:
Given Name:
Pharmacist registration number (PHA):

New Director 4
Family Name:
Given Name:
Pharmacist registration number (PHA):

New Director 5
Family Name:
Given Name:
Pharmacist registration number (PHA):

New Director 6
Family Name:
Given Name:
Pharmacist registration number (PHA):

If more than 6 directors, you must 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)*

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

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

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

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

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

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

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

NEW 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 *(if No provide details below)*** ☐ **Yes *(if Yes proceed to Declaration)***

TRUST NAME

TRUSTEES
Name:
Name:
Name

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

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

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

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

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

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

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

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

DECLARATION – *(Must be completed by all new owners or directors)*			
I, the undersigned, understand my obligations as a licensee under the Public Health Act 1997. I declare that the proceeding 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 that six owners or directors, you must attach signatures separately

CREDIT CARD DECLARATION - IF PAYING BY CREDIT CARD

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

SIGNATURE: ______________________________ **DATE:**______________________________

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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 (✓)

☐ **Cash** ☐ **Cheque** ☐ **Credit Card**

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

CREDIT CARD DECLARATION - IF PAYING BY CREDIT CARD

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

Fee $374

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: ____

....

CREDIT CARD DETAILS

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

Credit Card No **Expiry Date**

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐/☐☐