



ACT
Government

ACT Health

**MEDICINES POISONS &
THERAPEUTIC GOODS
APPLICATION TO AMEND LICENCE**

PURPOSE

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

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 form.
- You cannot amend the licence holder with this form. A new application must be submitted.
- Complete this form using a black or blue pen only and return with a **fee of \$41.00**.
- This form may be used to amend the following licence types:
 - First Aid Kit Licence
 - Pharmacy Medicines Rural Committees Licence
 - Research & Education Program Licence
 - Dangerous Poisons Manufacturers Licence
 - Medicines Wholesalers Licence
 - Dangerous Poisons Suppliers Licence

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

PARTICULARS OF BUSINESS AMENDMENT (CONTINUED)
SECURITY ARRANGEMENTS
<i>Please provide details:</i>

AUTHORISED PERSON DETAILS - <i>Applicable to First Aid Kit licence ONLY</i>				
Details of each additional person proposed to be authorised to deal under the licence. If insufficient space provided to record all details, please attach additional information to this application. <i>Note: Occupation must be a registered nurse or ambulance paramedic.</i> <i>Ambulance paramedic qualifications must be an Associate Diploma Health Science (Ambulance Officer) or equivalent.</i>				
Given Names	Family Name	Residential Address	Occupation	Qualifications & Board Registration No. (if applicable)

DETAILS OF USE - <i>Applicable to First Aid Kit licence ONLY</i>
<i>Details of the situations in which the proposed medicines will be used (e.g. operational protocols).</i> <i>Details of workplaces and/or community venues at which the relevant medicines are proposed to be administered.</i>

SUPERVISOR – <i>Applicable to Research & Education, Medicines Wholesalers and Dangerous Poisons licences ONLY</i>	
GIVEN NAME:	FAMILY NAME:
BUSINESS NUMBER:	MOBILE:
QUALIFICATIONS*:	

*Supervisor Qualifications, for Research and Education Program, refer to academic, professional or other relevant experience.

PARTICULARS OF BUSINESS AMENDMENT <i>(CONTINUED)</i>	
RESEARCHER DETAILS - <i>Applicable to Research and Education Program licences ONLY</i>	
GIVEN NAME:	FAMILY NAME:
BUSINESS NUMBER:	MOBILE:
QUALIFICATIONS*:	

**Researcher Qualifications: for Research and Education Program, researchers refer to academic, professional or other relevant experience.*




DETAILS OF PROGRAM - <i>Applicable to Research and Education Program licence ONLY</i>
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>

DECLARATION – <i>Applicable to all licences</i>
<p>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.</p> <p>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.</p>
<p>NAME: _____ POSITION: _____</p> <p>SIGNATURE: _____ DATE: _____</p>

CREDIT CARD DECLARATION - IF PAYING BY CREDIT CARD
<p><input type="checkbox"/> I agree to the credit card (details provided at Part K) being debited the required fee and credit card details destroyed immediately once the transaction is processed.</p>
<p>SIGNATURE: _____ DATE: _____</p>

PART K - 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	<p>Please Note:</p> <ol style="list-style-type: none"> 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.

Contact Person: _____

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

Credit Card No **Expiry Date**

/

Fee \$41.00

GST is not applicable under section 81-5 of the A New Tax System (Goods and Services Tax) Act 1999.

I agree that the Health Protection Service debit my account the above fee.

Card Holders' Name: _____

Card Holder's Signature: _____ **Date:** ____/____/____

Daytime Phone No: _____