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**: | **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 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 the **fee.**
- This form may be used to amend the following licence types:
  - First Aid Kit Licence
  - Research & Education Program Licence
  - Medicines Wholesalers Licence
  - Pharmacy Medicines Rural Committees Licence
  - Dangerous Poisons Manufacturers 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:** | **By Post:** | **By Fax:** | **By Email:** |
|---|---|---|---|
| Health Protection Service<br>Howard Florey Centenary House<br>25 Mulley Street<br>HOLDER ACT 2611 | Health Protection Service<br>Locked Bag 5005<br>WESTON CREEK ACT 2611 | (02) 5124 5554 | hps@act.gov.au |

| **REQUIRED INFORMATION** ***(must be completed)*** | | |
|---|---|---|
| **LICENCE NUMBER:** | **FILE NUMBER:** | **EXPIRY DATE:** |
| **TRADING NAME:**<br>*(As appears on current licence/permit certificate)* | | |

**PARTICULARS OF BUSINESS AMENDMENT** ***(Must be completed)***

***Please indicate which amendment(s) you are applying for and ONLY complete the sections relevant to your changes.***

| | | | |
|---|---|---|---|
| ☐ Business Details | ☐ Contact Details | ☐ Postal Details | ☐ Authorised Substance |
| ☐ Authorised Person | ☐ Details of Use | ☐ Supervisor | ☐ Researcher Details |
| ☐ Details of Program | ☐ Security Arrangements | | |

| **BUSINESS DETAILS** | | |
|---|---|---|
| **NEW TRADING NAME:** | | |
| ***PHYSICAL ADDRESS OF BUSINESS*** | | |
| **SHOP NUMBER:** | **PROPERTY NAME:** | |
| **STREET ADDRESS:** | | |
| **SUBURB:** | **STATE:** | **POSTCODE:** |

| **CONTACT DETAILS – ONSITE PERSON** | |
|---|---|
| **GIVEN NAME:** | **FAMILY NAME:** |
| **BUSINESS PHONE:** | **MOBILE PHONE:** |
| **AFTER HOURS PHONE:** | **FAX:** |
| **EMAIL ADDRESS:** | |

| **POSTAL DETAILS – BUSINESS CORRESPONDENCE POSTAL ADDRESS** | | |
|---|---|---|
| **STREET NUMBER/PO BOX:** | **STREET NAME:** | |
| **SUBURB:** | **STATE:** | **POSTCODE:** |

**AUTHORISED SUBSTANCE**

**SUBSTANCE DETAILS:**

| NAME OF SUBSTANCE | STRENGTH | FORM OF SUBSTANCE | MAXIMUM QUANTITY* | TOTAL QUANTITY* |
|---|---|---|---|---|
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***** *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.

| **PARTICULARS OF BUSINESS AMENDMENT *(CONTINUED)*** |
|---|
| **SECURITY ARRANGEMENTS** |
| *Please provide details:* |
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**AUTHORISED PERSON DETAILS - *Applicable to First Aid Kit licence <u>ONLY</u>***

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.
*<u>Note:</u> Occupation must be a registered nurse or ambulance paramedic.*
*Ambulance paramedic qualifications must be an Associate Diploma Health Science (Ambulance Officer) or equivalent.*

| **Given Names** | **Family Name** | **Residential Address** | **Occupation** | **Qualifications & Board Registration No.** (*if applicable*) |
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**DETAILS OF USE - *Applicable to First Aid Kit licence <u>ONLY</u>***

*Details of the situations in which the proposed medicines will be used (e.g. operational protocols).*
*Details of workplaces and/or community venues at which the relevant medicines are proposed to be administered.*

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

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

| **PARTICULARS OF BUSINESS AMENDMENT *(CONTINUED)*** | |
|---|---|
| **RESEARCHER DETAILS - *Applicable to Research and Education Program licences ONLY*** | |
| **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 - *Applicable to Research and Education Program licence ONLY*** |
|---|
| **PROGRAM/PROJECT TITLE:** |

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

**DECLARATION – *Applicable to all licences***

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:** _____

**CREDIT CARD DECLARATION - IF PAYING BY CREDIT CARD**

☐ 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.

**SIGNATURE:** _____ **DATE:**_____

## PART K - PAYMENT

### How to Pay

| | |
|---|---|
|  Fax: 5124 5554<br>MasterCard / Visa accepted<br>**(Not accepted where plans are involved)** |  By Mail: Health Protection Service<br>Locked Bag 5005 Weston Creek ACT 2611. |
|  In Person: Health Protection Service<br>25 Mulley Street Holder ACT 2611 | **Please Note:**<br>1. All paperwork must be completed and signed.<br>2. Where plans are involved, the originals must be received prior to the granting of your licence/registration certificate.<br>3. Applications sent by fax should **NOT** also be mailed. |

### Payment Method

Please Tick (ü)

☐ **Cheque** ☐ **Credit Card**

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

**Contact Person**: _____

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

**Credit Card No** **Expiry Date**

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐/☐☐

## Fee $45.65

***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: _____