

# 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](http://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](http://www.health.act.gov.au/hps)

### General Enquires:

(02) 6205 1700

### Email Address:

[hps@act.gov.au](mailto: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 and the ACT Opioid Maintenance Treatment Guidelines.
- 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  
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) 6205 1705

### By Email:

[hps@act.gov.au](mailto: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 <b>OR</b> 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 ( <i>Mr, Ms, Dr, Prof</i> )	GIVEN NAMES	FAMILY NAME
APPLICANT RESIDENTIAL ADDRESS ( <i>Property Name, Unit, Flat Number, Street Number, Street Name</i> )		
CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE
POSTAL ADDRESS ( <i>If different to above company address</i> )		
CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE
HOME TELEPHONE NUMBER	MOBILE NUMBER	
WORK NUMBER	EMAIL ADDRESS	
AUSTRALIAN BUSINESS NUMBER (A.B.N) ( <i>if applicable</i> )		

**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](http://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 – *If applicable***

**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 *(if applicable)***

OCCUPATION:

PHARMACIST REGISTRATION NUMBER:

**APPLICANT TRAINING IN OPIOID DEPENDENCY TREATMENT**

APPLICANT HAS COMPLETED REQUIRED TRAINING COURSE:  Yes  No

COPY OF TRAINING CERTIFICATE ATTACHED:  Yes  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**

*Please provide details.*

---



---



---



---



---



---



---



---



---



---

**Please ensure both declarations on page 6 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:** \_\_\_\_\_

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