

HEALTH CARE FACILITY NEW LICENCE APPLICATION

PURPOSE

This form is to be used to apply for a licence under the *Public Health Act 1997* (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
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INSTRUCTIONS FOR COMPLETION & IMPORTANT INFORMATION

Licence is issued to the applicant for the business, 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 registered. Companies operating as trustees for a trust will be registered in the Company name only.
- (2) Applications listing a partnership as the Applicant will not be accepted. If your business is operated by a partnership, one or more of the individuals in the partnership will need to be listed.
- (3) Parts B and C of this application form must be completed separately by each individual listed as an applicant. Extra copies of Parts B and C are available at www.health.act.gov.au/hps or by contacting the HPS.

- A floor plan showing the layout of all fixtures and fittings of the premises must accompany this application. Plans may also be submitted electronically to hps@act.gov.au.
- Complete this form using a black or blue pen and return with the **relevant fee**:

<u>Premise Type</u>	<u>Fee (one year)</u>
Accredited Health Care Facility <200 beds	\$555
Accredited Health Care Facility >200 beds	\$1109
Non Accredited Health Care Facility	\$831
Health Care Facility – Sole Dentist	\$222

Is the licence to be issued to a Corporation (a Company, Incorporated Association, Government agency or a Registered Charitable Organisation)?

- YES Complete PARTS A, C and D** of this application. NB: Trusts or Partnerships will not be registered. Companies operating as trustees for a trust will be registered in the Company name only.
- NO Complete PARTS B, C and D** of this application. Separate details must be completed for each individual listed as an owner.

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:	By Post:	By Fax:	By Email:
Health Protection Service Howard Florey Centenary House 25 Mulley Street HOLDER ACT 2611	Health Protection Service Locked Bag 5005 WESTON CREEK ACT 2611	(02) 6205 1705	hps@act.gov.au

CHECKLIST

If applying as an INDIVIDUAL	
<input type="checkbox"/>	Part B completed and signed: Ownership details for an individual (one copy for each owner)
<input type="checkbox"/>	Part C complete: Proof of identification (one copy for each owner)
<input type="checkbox"/>	One form of current photographic identification (for each signatory) presented in person at the Health Protection Service OR One form of current photographic identification (for each signatory) sighted and certified by an authorised witness for each signatory.
<input type="checkbox"/>	Part D completed: Particulars of business
<input type="checkbox"/>	Attached detailed copies of plan OR Plans previously submitted for assessment
<input type="checkbox"/>	Declaration signed (page 7)
<input type="checkbox"/>	Attached payment (page 9)
If applying as a CORPORATION	
<input type="checkbox"/>	Part A completed and signed: Ownership details of a company
<input type="checkbox"/>	Attached current company extract issued by the Australian Securities and Investment Commission (ASIC)
<input type="checkbox"/>	Part C complete: Proof of identification (for company agent)
<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 D completed: Particulars of business.
<input type="checkbox"/>	Attached detailed copies of plan OR Plans previously submitted for assessment
<input type="checkbox"/>	Declaration signed (page 7)
<input type="checkbox"/>	Attached payment (page 9)

PART B – APPLICANT DETAILS FOR AN INDIVIDUAL (Do NOT complete if you are applying as a company)

TITLE (Mr, Ms)	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 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 SIGNATURE
<p>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.</p> <p>Signature: _____</p> <p>Date: / /</p> <p>Note for Multiple Owners: (for example partnerships) Copies of Part B are available at www.health.act.gov.au/hps or by contacting the HPS.</p>

PART C – PROOF OF IDENTIFICATION (Must be completed for company (by registered agent) and individual applicants)

One form of current photographic identification sighted and certified by an authorised witness must be provided for each signatory in Parts A or B.

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"/>

Note for Multiple Owners: (for example partnerships) Copies of Part C are available at www.health.act.gov.au/hps or by contacting the HPS.

PART D - PARTICULARS OF BUSINESS (Must be completed)

TRADING NAME		
PHYSICAL ADDRESS OF BUSINESS		
PROPERTY NAME:		
STREET ADDRESS:		
SUBURB:	STATE:	POSTCODE:

BUSINESS CONTACT PERSON		
GIVEN NAME:	FAMILY NAME:	
BUSINESS PHONE:	MOBILE PHONE:	
AFTER HOURS PHONE:	FAX:	
EMAIL ADDRESS:		
BUSINESS CORRESPONDENCE POSTAL ADDRESS		
NUMBER:	STREET NAME:	
SUBURB:	STATE:	POSTCODE:

HEALTH CARE FACILITIES DETAILS	
Please indicate all procedures which will be undertaken within the facility in relation to which license coverage is sought:	
Administration of a general anaesthetic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spinal anaesthetic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epidural anaesthetic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Major regional block anaesthetic not including mandibular blocks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intravenous sedative	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dialysis, haemofiltration or haemoperfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prolonged intravenous infusion of a single cytotoxic agent or sequential intravenous infusion of more than one cytotoxic agent	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac catheterisation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of patient beds in facility: _____ <i>(please see front page to establish required fee)</i>	
Are overnight patient stays provided on the facility's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the facility hold Accreditation? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, Expiry Date:</i> _____	
<i>If Yes please enter accrediting agency details: Name:</i> _____	
Is the sterilisation of surgical equipment completed on site? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If Yes please provide details of person/company responsible for sterilisation:</i>	
Name: _____ Phone: _____ Fax: _____	
Company (if applicable): _____	

Does the facility employ a person responsible for Infection Control? Yes No
 If Yes please provide person's details: **Name:** _____ **Phone:** _____
 Percentage of time dedicated to infection control: _____%

Does the facility have an Infection Control Policy and Procedures Manual? Yes No
When was the facility procedures manual last updated/reviewed? ____/____/____

Is patient food prepared at the facility? Yes No If Yes please provide Food Business Registration No. _____
 Please provide details of person/company responsible for preparation of patient food:
Name: _____ **Phone:** _____ **Fax:** _____
Company (if applicable): _____

Please provide person/company details of responsible party for the removal of clinical waste from the facility:
Name: _____ **Phone:** _____ **Fax:** _____
Company (if applicable): _____ **ABN:** _____

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:** _____

CREDIT CARD DECLARATION - IF PAYING BY CREDIT CARD

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

SIGNATURE: _____ **DATE:** _____

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