PRIVATE HOSPITALS AND HEALTH SERVICES ACT 1927

Addition of Specialties/Procedure to a Licence Request Form

Facility Name:	
Facility Address:	
Licensee Name:	

INSTRUCTIONS

Complete this form if you wish to add a specialty/procedure to a licence.

1. Please complete the entire form.
2. Please respond to each question. If a question is not applicable write N/A.
3. The form can be completed electronically or written on a hard copy and must include a signature.
4. Return completed form to LARULicensing@health.wa.gov.au.
5. Reception phone (08) 6373 2347 for any further enquiries.

PLEASE NOTE:

1. *LARU requires 28 working days to complete a review of this request.*
2. *If your request involves clinical trials and/or new/innovative medical procedures these will need to be approved and supervised by a human research ethics committee that is registered with the National Health and Medical Research Council*.

1	Description and specific requirements	
1.1	**Additional Service** What are the services/procedures you require to be included on your licence?	
1.2	**Type of patients** For whom are the services/procedures intended? Adults, Children or both? If children are to be treated, include the age range.	
1.3	**Commencement Date of Service** What is the date you propose to commence your service? ***Note - As soon as possible is not an acceptable answer***	
1.4	**Reason for Service** What is the rationale for the additional service?	
1.6	**Number of Patients** What is the number of patients to be treated? - Per session? - Per day? - Which days?	
1.7	**Admission and Discharge Criteria** What are the specific admission and discharge criteria for patients accessing this service? (Attach if available)	
2	**Building**	
2.2	Does your building comply with current guidelines?	
2.3	Are there any dispensations/conditions on your building?	
2.4	Provide a scaled site plan (minimum	

	A1 size) and floor plan for the relevant area including areas where a room (s) will have a change of function.	
3	**Equipment (Theatre/Recovery/Ward)**	
3.1	Is additional equipment required for the service? If so what type?	
3.2	What area/space will be used for storing the equipment? (Highlight on a building plan and attach)	
3.3	Is commissioning of the equipment required?	
3.4	Is medical personnel and other staff training in using the equipment required?	
3.5	If so how and when will this training occur?	
3.6	Is there any additional cleaning associated with equipment?	
4	**Instrumentation**	
4.1	Are additional instruments required for the service? If so what type?	
4.2	Is there capacity within the current CSSD to reprocess the additional instruments?	
4.3	Is validation of the instrument load/s required?	
4.4	Is medical personnel and other staff training required on the use of the additional instruments?	
4.5	Where will the additional instruments	

	be stored? (Highlight on building plan and attach)	
5	**Consumables**	
5.1	Are additional consumables (sterile and non-sterile) required for the service? If so what?	
5.2	Where will the consumables be stored?	
6	**Staffing**	
6.1	What number of medical practitioners and their credentials will be involved in the additional service?	
6.2	Are additional training/competencies required for medical practitioners?	
6.3	Will additional other staff be required? If so, identify category and numbers e.g. RN's, EN's, PCA's, CSD technicians, other	
6.4	What additional/specialty qualifications / training / competencies are required for other staff?	
7	**Impact on other Services**	
7.1	Does the additional service require support from speciality clinical services (ICU, CCU, and HDU)? If yes describe.	
7.2	Does the additional service require support from other services in the facility? (e.g. radiology, pharmacy, pathology, other). If yes describe.	
7.3	Have cleaning, waste management and maintenance requirements been assessed and planned?	
8	**Patient Related**	

8.1	Are there any clinical requirements that impact on the patients? (e.g. adult/child separation, pre-procedure treatments such as eye drops or other medical checks)	
8.2	If so, is there enough staff and physical space for this to occur?	
8.3	Are there any environmental matters that impact on patient flow (e.g. parking, waiting area or post procedure recovery)?	

9	**Management/Governance**	
9.1	Has the additional service been approved by the Medical Advisory Committee and the Credentialing Committee? Please provide date of committee meeting when the approval was granted.	
9.2	Has the additional service been reviewed by the Infection Control (IC) Committee/Consultant? Have any IC recommendations been made and implemented?	
9.2	What specific policies and/or procedures will impact on this additional service?	
9.3	Have policies and/or procedures been drafted or updated to reflect the additional service?	
10	**Licence**	

10.1	Does your licence have any conditions or dispensations?	
10.2	Will the maximum number of patients that may be treated at any one-time increase?	
10.3	Will the maximum number of beds increase?	
11	**Other**	
11.1	Any other relevant information?	

Licence Holder or Authorised Delegate Declaration

I declare as the ☐ Licence Holder or ☐ Authorised Delegate that:

- The information contained in this form is true and correct; and
- I am duly authorised to make this declaration.

Name:	
Position Title:	
Signature:	
Date:	