Medical Treatment Permit

Application Form

*Medicines and Poisons Act 2014*

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| INSTRUCTIONS and INFORMATION | | |
|  | This application form is for a new Health Service Permit fora medical business to purchase scheduled medicines for the treatment of employees at a work site. This type of Permit is intended for remote settings where access to medicines and medical care is limited.  This application form **MUST** be completed by the nominated applicant who will be:   * the individual Permit holder or * a corporate officer, if the Permit is being issued to a body corporate or * a partner, if the Permit is to be issued to a partnership   The applicant must be suitably qualified and understand the requirements and terminology contained in this application form.  **All communication will ONLY be with the nominated Permit holder, corporate officer or partner**  To request a change to an existing Permit, please complete an Application to Change a Medical Treatment Permit, found at: [Application forms for Licences and Permits](https://ww2.health.wa.gov.au/Articles/A_E/Application-forms-for-Licences-and-Permits)  There are five parts to this form:  Part 1: Application form for a Health Service Permit for Medical Treatment.  Part 2: Personal Information: Identification, Fitness and Probity (PIF) to be completed by the nominated applicant.  Part 3: Personal Information: Identification, Fitness and Probity (PIF) to be completed by the nominated responsible person.  Part 4: Payment and checklist.  Part 5: Appendices | |
|  | **Permit holder and qualifications**  **2.1** **Permits can be issued to:**   1. Individual applicant who is a medical practitionerwho must:  * complete Part 2: Personal Information: Identification, Fitness and Probity and sign the declaration at Section 17. * be registered with the Australian Health Practitioner Regulation Agency (AHPRA) * have authority within the business to determine policies and procedures in relation to managing the medicines on the Permit.  1. Body corporate (corporation) or partnership and:    * each corporate officer (directors, company secretary, chief executive officer or general manager and chief financial officer) or each partner must complete Part 2: Personal Information: Identification, Fitness and Probity and sign the declaration at Section 17.    * each corporate officer or partner must provide a National Police Clearance (NPC) certificate which is less than 12 months old.   **2.2 Permits issued to a corporation or partnership**  The corporation or partnership must always employ a Medical Director i.e. medical practitioner registered with AHPRA, who is:   * the most senior medical practitioner responsible for provision of Medical Treatment services and * must have authority within the business to determine policies and procedures in relation to managing medicines.   **2.3 Permit holder responsibilities**  If the Permit is issued, it is the responsibility of the applicant (Permit holder) to ensure compliance with the *Medicines and Poisons Act 2014* and Regulations 2016 and any conditions placed on the Permit.  The Permit holder must also consider whether they have capacity to ensure compliance with the *Medicines and Poisons Act 2014* and Regulations 2016 and compliance with conditions placed on the Permit for every site listed on the Permit. The Department may request further information in relation to this capacity.  The Permit holder should review standard operating procedures used by the organisation to check they are consistent with the mandatory requirements of the legislation and any conditions placed on the Permit.  There are penalties under the Act for providing false or misleading information when applying for a Permit. | |
|  | **Person responsible for a site and qualifications**  An individual person must also be nominated to have overall responsibility for each site included on the Permit. The role of the responsible person is to manage the medicines on a day to day basis and be the contact person if the Permit holder is not available.  The responsible person for a site must:   * be employed or contracted by the Permit holder * be the most senior medical practitioner for the site. See 3.1 and 3.2 for other options. * complete Part 3: Personal Information: Identification, Fitness and Probity * sign the declaration at Section 22.   **3.1 Responsible person for a Permit issued to an individual medical practitioner:**  The responsible person for a site when a Permit is issued to an individual medical practitioner can be:   1. the individual Permit holder i.e. medical practitioner **or** 2. another medical practitioner who is the most senior medical practitioner for the site.   **3.2 Responsible person for a Permit issued to a corporation or partnership**  The responsible person for a site when a Permit is issued to a corporation or partnership can be:   1. the most senior medical practitioner for the site, **or** 2. the Medical Director employed by the corporation or partnership. Refer to 2.2   Please note: a responsible person must consider whether they have capacity to oversee the day to day management of medicines at every site for which they are responsible. Where a single person is responsible for multiple sites, the Department may request further information in relation to this capacity. |
|  | **Administration and supply of scheduled medicines**  Where administration or supply of scheduled medicines will occur without a prescriber issuing a verbal or written direction for each individual patient, there must be a Structured Administration and Supply Arrangement (SASA)1 in place for each medicine.  Only a medical practitioner can issue a SASA.  A SASA cannot be written for the supply of a Schedule 8 medicine for a patient to take away.  Copies of SASAs issued under Health Service Permits must be sent to the Department of Health.  SASAs do not have to accompany this Application Form and the permit may be issued prior to the receipt of SASAs.  1 Information about SASAscan be found at: [Information about SASAs](http://ww2.health.wa.gov.au/Articles/S_T/Structured-Administration-and-Supply-Arrangements)  This type of permit is issued with the condition that there must be compliance with the [Code of Practice for Health Service Permits for Medical Treatment](http://ww2.health.wa.gov.au/Articles/N_R/Providing-medicines-for-employees-at-remote-workplaces). It is recommended that applicants read this Code prior to applying for this type of permit. |
|  | **Taking over from another medical treatment provider**  If you are contracted as the new medical treatment provider for a site that is already named on another Medical Treatment Permit, the Department requires the current Permit holder to remove this site from their Permit by completing an Application to Change a Medical Treatment Permit. The application to remove this site from the other Permit must be received by the Department prior to adding this site to your Permit. You may have to liaise with the company contracting you as the new medical treatment provider, so that the change in medical treatment provider is coordinated, this ensures the medicines stored at the site are always on a Permit and the availability of medicines to employees is consistent.  *The Department does not coordinate the change in medical treatment providers or their Permits.*  *It is the responsibility of the medical treatment providers and the company contracting them to manage the change in a timely manner.* |

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|  | **Schedule 2, 3, 4 and 8 medicines**  The sections relating to required scheduled medicines are divided into two different sections,  Sections 5 and 6 relate to storage and use of Schedule of 2,3, and 4 medicines and Section 7 relates to Schedule 8 (Controlled Drug) medicines. |
|  | **Required documents**  The applicant and responsible person are required to submit copies of certain documents.  If documents are not in English, also attach a translation certified as completed by a National Accreditation Authority for Translators and Interpreters (NAATI) accredited translator.  Copies of photographic identification documents, such as a driver’s licence or passport must be certified as a true copy. A list of people who can certify copies of documents is found in Appendix C. | |
|  | **Signatures**  All signatures must be signed in ink or via a verifiable electronic signature. An electronic signature is only acceptable if the submitted application allows the Department to verify the signature.  A “signature” that is copied and pasted and a “signature” that is the person’s name in a font style resembling handwriting will not be accepted.  The nominated Permit holder must sign the Declaration at Section 11 for obtaining a Permit. If the Permit will be held by a corporation or partnership, a corporate officer or partner must sign the Declaration. | |
|  | **Standard Operating Procedures (SOPs).**  This application requires the applicant to confirm the Medical Treatment provider has a number of SOPs.  The Department may request that SOPs be made available for auditing purposes.  The issuing of a Permit does not imply approval or otherwise of the SOPs. | |
|  | **Issuing a Permit**  Applying for a Permit does not guarantee a Permit will be issued.  An application must be deemed complete and payment received before the application is sent to the approvals team where a desktop risk assessment is conducted by an authorised officer.  The Department assesses each application individually and may decide against issuing a Permit.  If the Permit is issued:   * it will expire 1 year after the date of issue, * a renewal application will be mailed to the postal address approximately 2 months prior to expiry.   + It is the Permit holder’s responsibility to inform the Department if the postal address changes.   If the Permit is not issued:   * the applicant will be provided with details of the reasons in writing, * the yearly Permit fee will be refunded, * the application fee is non-refundable. | |
|  | **Processing applications**  Applications will be processed in order of receipt after payment has been processed by Finance, provided the required fee has been paid. To ensure a timely decision about your application, please:   * Complete all required Sections of the application, * **Attach** all requested documentation to the application, * Respond to requests from the Department for additional information as soon as possible, * Make sure appropriate staff are available if the Department needs to conduct a site inspection, * Please submit this application as a Word document or PDF and not a photograph. | |
|  | **Extra information**  When applying for a Permit please refer to the: [Guide to applying for a Licence or Permit](https://ww2.health.wa.gov.au/Articles/A_E/Application-forms-for-Licences-and-Permits) | |
|  | **Submitting the application**  Please email completed form and other requested documentation to [mprb@health.wa.gov.au](mailto:mprb@health.wa.gov.au) | |
| **Incomplete applications may be delayed or returned to the applicant** | | |
| **Please keep a copy of the completed application form for reference** | | |

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| PART 1: APPLICATION for a MEDICAL TREATMENT PERMIT |

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| Details of applicant (nominated Permit holder) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Refer to instruction number 2, for information on the requirements for being a Permit holder. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Legal Entity (may be different to business or trading name): | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  |
| Business or trading name: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  |
| Type of Permit (tick which one applies): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual medical practitioner (on behalf of a business). Complete section 1.1 and 1.3 to 1.6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Body Corporate (corporation) or partnership. Complete Section 1.2 and 1.3 to 1.6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.1** | | **Permit to be issued to an individual medical practitioner** (on behalf of a business) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Dr. | |  | | | Forename/s: | | | |  | | | | | | | | | | Surname: | |  | | | | | |  | | | |
|  | | Postal address: | | | | | |  | | | | | | | | Suburb: | |  | | | | | | Postcode: | |  | |  | | | |
|  | | Telephone: | | | |  | | | | | | | Fax: |  | | | | | | Email: | |  | | | | | |  | | | |
|  | | Position in business: | | | | | | | |  | | | | | | | | | | | | | | | | | |  | | | |
|  | | The applicant must **complete Part 2**: Personal Information: Identification, Fitness and Probity. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.2** | | **Corporation or partnership.** Tick which one applies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | **Corporation** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | Each corporate officer: directors, company secretary, chief executive officer, general manager and chief financial officer **must complete Part 2:** Personal Information: Identification: Fitness and Probity; and | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | 1.2.1 **Attach** a copy of Current Company Extract from ASIC (with details of company directors and secretary) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | **Partnership** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | Each partner **must complete Part 2,** Personal Information: Identification: Fitness and Probity. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Section 2 must be completed if the Permit is to be issued to a corporation or partnership. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.3** | | **Business/Trading name** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **If** the business has a Business/Trading Name, **attach** a copy of certificate of Record of Registration for Business Name or Current Business Name Extract (from Australian Securities and Investment Commission [ASIC]). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.4** | | **Australian Business Number**: | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | |
| **1.5** | | **Australian Company Number** (ACN) or Australian **Registered Body Number** (ARBN), if applicable: | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| **1.6** | | **Registered business address of applicant:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | Same as postal address shown above or: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Address: | | | |  | | | | | | | | | | Suburb: | |  | | | | | | | | Postcode: | |  | | |  | |
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**Part 1: Application for a Medical Treatment Permit**

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| Permits issued to a corporation or partnership | | | | | | | | | | | |
| Is the applicant a corporation or partnership? | | | | | | | | | | | |
|  | No, the applicant is an individual medical practitioner | | | | | | | | | | |
|  | Yes: complete Section 2.1 and 2.2 | | | | | | | | | | |
| **2.1** | Check to confirm the corporation or partnership always employs a Medical Director i.e., a registered medical practitioner who has authority within the business to determine policies and procedures in relation to managing medicines | | | | | | | | | | |
| **2.2** | Details of medical director **employed** by the corporation or partnership. | | | | | | | | | | |
|  | Dr. |  | Forename(s): | |  | Surname: | |  | | |  |
|  | AHPRA registration number: | | |  | | | Expiry date: | |  |  | |
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| Site and security details | | | | | | | | | | | | | | | | | | | | | | | | | |
| Section 3 must be completed for every site listed on the Permit. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is this site being transferred from a different Medical Treatment provider? See instruction 5 | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes: | | Name of Medical Treatment provider: | | | | | | | | |  | | | | | | | | | | | | | |  |
|  | | The Department requires the current Permit holder to remove this site from their Permit by completing an Application to Change an existing Medical Treatment Permit. This form must be received by the Department prior to adding this site to your Permit | | | | | | | | | | | | | | | | | | | | | | | |
| **3.1** | **Site details** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Name of resource company contracting the medical treatment provider: | | | | | | | | | | | | | | | |  | | | | | | | |  |
|  | Site name: | | |  | | | | | | | | | | | | | | | | | | | | |  |
|  | Site address: | | | | |  | | | Suburb: | | | |  | | | | | | | | | Postcode: | |  |  |
|  | Telephone: | | | |  | | | Fax: | |  | | | | | | | | Email: |  | | | | | |  |
|  | Date of possession of the site /commencement of service at the site: | | | | | | | | | | | | | |  | | | | | |  | | | | |
|  | Note: Permit will be issued with “Valid from” date on or after this date | | | | | | | | | | | | | | | | | | | | | | | | |
| **3.2** | **Geographic location** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | GPS coordinates for site: | | | | | | | | | | |  | | | | | | | | | | | | |  |
|  | Distance to the nearest population centre: | | | | | | | | | | |  | | | | | | | | | | | | |  |
|  | Number of personnel being serviced at the site: | | | | | | | | | | |  | | | | | | | | | | | | |  |
| **3.3** | **Medical practitioner responsible for the site:** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Please refer to instruction number 3, for who is eligible to be responsible for a site. | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Name of nominated responsible person for the site named in Section 3.1 | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Dr | | Forename(s): | | | |  | | | | | | | Surname: | |  | | | | | | | | |  |
|  | The nominated responsible person **must complete Part 3:** Personal Information: Identification, Fitness | | | | | | | | | | | | | | | | | | | | | | | | |
| **3.4** | **Employees at site:** | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Are employees on the mining/resource/industrial site where the health service permit site is located from one mining/resource/industrial company? | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Yes | | | | | | | | | | | | | | | | | | | | | | | | |
|  | No: Will you be treating all employees on the mining/resource/industrial site? | | | | | | | | | | | | | | | | | | | Yes | | | No | | |
| Section 3 continues next page | | | | | | | | | | | | | | | | | | | | | | | | | |

**Part 1: Application for a Medical Treatment Permit**

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| **3.5** | **RFDS and another health service/medical treatment provider** | | | | |
|  | Does the site currently have a Royal Flying Doctor (RFDS) medicine chest? | | | | |
|  | No | | | | |
|  | Yes: the medicine chest must be returned to the RFDS, please contact RFDS to organise its return. | | | | |
| **3.6** | Is this site already on another Medical Treatment Permit? Please see instruction number 5. | | | | |
|  | No | | | | |
|  | Yes: The Department requires the current permit holder to remove this site from their Permit by completing an Application to Change a Medical Treatment Permit. This form must be received by the Department prior to adding this site to your permit. | | | | |
| **3.7** | **Building security** | | | | |
|  | Please check all that apply: | | | | |
|  | Dedicated monitored alarm system | | Video surveillance system (CCTV) | Motion detectors | |
|  | Perimeter fence with lockable gate | | Perimeter alarm | | |
|  | Other – please describe: |  | | |  | |
|  | | | | | |

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| Details of staff administering and supplying medicines on site | | | | | | |
| Qualifications of staff who will be administering and supplying medicines on site: | | | | | | |
| 4.1 | Medical practitioner | | | Registered nurse1 | Enrolled nurse2 | AHPRA Registered paramedic |
| 4.2 | Medic3 | | |  |  |  |
|  | |  | Please check to confirm all medics3 employed by the Medical Treatment provider have a minimum qualification of Cert IV in Healthcare Ambulance, First Aid or equivalent from a Registered Training Organisation (RTO) | | | |
|  | |  | Please check to confirm all medics3 employed by the Medical Treatment provider, provide a National Police Clearance certificate (NPC) issued in the last 12 months prior to commencing employment. | | | |
| 1 Includes Nurse Practitioner  2 An enrolled nurse can administer medicines unless they have a notation on their registration which advises that they have not completed education related to the handling of medicines.  3 A medic is not registered with AHPRA and does not have a Degree in paramedicine but has a minimum qualification of Cert IV in Healthcare Ambulance, First Aid or equivalent from a RTO. | | | | | | |

**Part 1: Application for a Medical Treatment Permit**

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| Medicines required, storage, record keeping and access | | | | | | | | | | | | |
| Section 5 must be completed for every site listed on the Permit | | | | | | | | | | | | |
| Please check all that apply: | | | | | | | | | | | | |
| Schedule 2- Pharmacy medicine | | | | | | | | | | Schedule 3 – Pharmacist only medicine | | |
| Schedule 4 – Prescription only medicine | | | | | | | | | | Schedule 8 – Controlled drug: complete Section 8 | | |
| **5.1 Storage and temperature monitoring of Schedule 2, 3, and 4 medicines** | | | | | | | | | | | | |
|  | | | | 5.1.1 | | | | Storage of non- refrigerated medicines in Schedule 2, 3, and 4 (Please check which one applies) | | | | |
|  | | | |  | | | | Locked room | Locked cupboard | | | |
|  | | | | 5.1.2 | | | | Storage of refrigerated medicines in Schedule 2, 3, and 4 (Please check which one applies) | | | | |
|  | | | |  | | | | Locked room with refrigerator | | | Locked refrigerator | |
|  | | | | 5.1.3 | | | | Temperature monitoring for refrigerated medicines in Schedule 2,3 and 4 | | | | |
|  | | | |  | | | | Please indicate how the temperature of refrigerated medicines will be monitored | | | | |
|  | | | |  | | | | Vaccine refrigerator with an inbuilt thermometer and data logger from which data can be downloaded. | | | | |
|  | | | |  | | | | Normal refrigerator with temperature data logger from which data can be downloaded. | | | | |
|  | | | |  | | | | Manual thermometers are not sufficient for continuous monitoring of temperature sensitive medicines.  The temperature data logger:   * must record multiple data points (not just maximum and minimum temperatures) and * must create an alarm if the temperature is outside the designated range. | | | | |
| **5.2 Storage area for medicines in Schedule 2,3, and 4** | | | | | | | | | | | | |
|  | | | | | Please provide information for all areas storing Schedule 2,3 and 4 medicines at the site: | | | | | | | |
|  | | | | | |  |  | | --- | --- | | Building name or number, room number | Building name or number, room number | |  |  | |  |  | |  |  | |  |  | | | | | | | | |
| **5.3 Record keeping** | | | | | | | | | | | | |
|  |  | | | | | Check to confirm records of administration and supply of Schedule 4 medicines are maintained in patients notes. | | | | | | |
|  |  | | | | | Check to confirm records of administration and supply of Schedule 4 medicines will be kept for at least 2 years. | | | | | | |
| **5.4 Access to Schedule 2, 3 and 4 medicines** | | | | | | | | | | | | |
|  |  | | | | | Please check to confirm only AHPRA registered health practitioners authorised under the *Medicines and Poisons Act 2014* to possess Schedule 2 ,3 and 4 medicines and employed by the Medical Treatment business will have unsupervised access to the medicines including access to keys and entry codes to storage areas. | | | | | | |
| **5.5 Preventing access to Schedule 2,3 and 4 medicines** | | | | | | | | | | | | |
|  | | Please describe how non-authorised staff such as workers, cleaners and visitors will be prevented from having access to Schedule 2, 3 and 4 medicines: | | | | | | | | | | |
|  | |  | | | | | | | | | | |
|  | |  | | | | | | | | | |  |
| **5.6 Loss or theft of Schedule 4 medicines** | | | | | | | | | | | | |
|  | | |  | | | | Please check to confirm any loss or theft of Schedule 4 medicines s will be reported to MPRB as soon as reasonably practicable using the form found at: [Reporting loss or theft of medicines and poisons](https://ww2.health.wa.gov.au/Articles/N_R/Reporting-loss-or-theft-of-medicines-and-poisons) | | | | | |

**Part 1: Application for a Medical Treatment Permit**

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| Administration and supply of Schedule 2,3 and 4 medicines to patients | | | | | | |
| Refer to instruction number 4 | | | | | | |
| **6.1 Type of health practitioner authorising administration and supply of Schedule 2, 3,4 medicines to patients** | | | | | | |
|  | 6.1.1  **Medical Practitioner** | | | | | |
|  | | 1. ***Administration*** of **Schedule 4 medicines** (please check ONE option only): | | | | |
|  | | | |  | Doses of **Schedule 4** medicines will only be *administered* by the medical practitioner or in accordance with a direction by a medical practitioner for each individual patient **OR** | |
|  | | | |  | A combination of individual directions to *administer* and Structured Administration and Supply Arrangements (SASAs)1 will be used for *administration* of doses of Schedule 4 medicines **OR** | |
|  | | | |  | All *administration* of doses of Schedule 4 will be in accordance with a SASA1 | |
|  | | 1. ***Supply*** of **Schedule 2,3** and **4** medicines for patients to take away (please check ONEoption only): | | | | |
|  | | | |  | Schedule 2,3, and 4 medicines will not be *supplied* to patients to take away **OR** | |
|  | | | |  | Schedule 2,3 and 4 medicines for patients to take away will be personally *supplied* by medical practitioner2 **OR** | |
|  | | | |  | A combination of individual supply by the medical practitioner and SASAs1 will be used to supply Schedule 2,3 and 4 medicines to the patient2**OR** | |
|  | | | |  | Schedule 2, 3 and 4 medicines will be *supplied* to patients to take away via SASAs1 only**2** | |
|  | | | | 1Note: Structured Administration and Supply Arrangements (SASA’s) can only be written:   * and approved by a medical practitioner and not a nurse practitioner * for acute conditions or a public health issue only   Information on SASAs are available at: [Structured Administration and Supply Arrangements](https://ww2.health.wa.gov.au/Articles/S_T/Structured-Administration-and-Supply-Arrangements)  Once completed, copies of SASAs must be forwarded to the Medicines and Poisons Regulation Branch.  Completion of SASAs is not required as part of the Permit application process. | | |
|  | | | | **2** Complete Section 6.2 | | |
|  | 6.1.2  **Nurse Practitioner** | | | | | |
|  | | 1. ***Administration*** of **Schedule 4** medicines | | | | |
|  | | |  | | | Check to confirm that **Schedule 4** medicines will only be *administered* by a nurse practitioner or *in* accordance with a direction by a nurse practitioner for each individual patient**.** |
|  | | 1. ***Supply*** of **Schedule 2,3** and **4** medicines for patients to take away (please check ONE option only): | | | | |
|  | | |  | | | Schedule 2,3, and 4 medicines will not be *supplied* to patients to take away **OR** |
|  | | |  | | | All Schedule 2,3 and 4 medicines for patients to take away will be personally *supplied* by nurse practitioner: complete Section 6.2 |
| **6.2 Supplying Schedule 2,3 and 4 medicines to patients** | | | | | | |
|  | Complete Section 6.2, only if Schedule 2,3 or 4 medicines will be supplied to patients to take away. | | | | | |
|  | Please check to confirm Schedule 2 and 3 medicines will only be supplied to patients in their original packs. | | | | | |
|  | Please check to confirm Schedule 4 medicines supplied to patients, will be labelled according to Appendix L of the [Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)](https://www.tga.gov.au/publication/poisons-standard-susmp) | | | | | |
|  | More information is found at: [Labels on Medicines and Poisons](https://ww2.health.wa.gov.au/Articles/J_M/Labels-on-medicines-and-poisons) and [Code of Practice for Health Service Permits for Medical Treatment](http://ww2.health.wa.gov.au/Articles/N_R/Providing-medicines-for-employees-at-remote-workplaces) | | | | | |
| Please note: under the Medicines and Poisons Regulations 2016, Schedule 2 and 3 medicines can be administered by any person, however the medical treatment organisation may have their own policy and procedures in relation to the administration of Schedule 2 and 3 medicines. | | | | | | |
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| Schedule 8 medicines (Controlled Drug) | | | | | | | | | | | | | | | | | | | | |
| Section 7 must be completed for every site listed on the Permit that will be storing Schedule 8 medicines. | | | | | | | | | | | | | | | | | | | | |
| Is this site being transferred from another Medical Treatment provider? Please see instruction number 5. | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | | | | | | | | | | | |
| Yes: | | | | | Name of other Medical Treatment provider: | | | |  | | | | | | | | | |  | |
|  | | | | | Are Schedule 8 medicines being transferred from the other Medical Treatment provider? | | | | | | | | | | | | | | | |
|  | | | | | No | | | | | | | | | | | | | | | |
|  | | | | | Yes:  please confirm an inventory of Schedule 8 medicines will be conducted at the time of handover. | | | | | | | | | | | | | | | |
| Will S8 medicines be stored in multiple areas/rooms/buildings at the site? | | | | | | | | | | | | | | | | | | | | |
| No: complete all of Section 7 | | | | | | | | | | | | | | | | | | | | |
| Yes, complete all of Section 7 for the first drug safe and Sections 7.1 and 7.3 for every other drug safe at the site | | | | | | | | | | | | | | | | | | | | |
| **7.1 Required Schedule 8 medicines – please list:** | | | | | | | | | | | | | | | | | | | | |
|  | Confirm address of site: | | | | |  | | | | | | | | | | | | | |  |
|  | 7.1.1 Location of drug safe (building number/name, room number/name): | | | | | | | | | | | |  | | | | | | |  |
|  | 7.1.2 Please list all required S8 medicines stored in the drug safe at the location named in Section 7.1.1 | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | | Name, strength and form of medicine | | | | | | | Quantity required | | | | Number of *human doses* | | |  | | | |
|  | | |  | | | | | | |  | | | |  | | |  | | | |
|  | | |  | | | | | | |  | | | |  | | |  | | | |
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|  | | |  | | | | | | |  | | | |  | | |  | | | |
|  | | | 7.1.3 Total number of *human doses* of S8 medicines stored in the safe: | | | | | | | | | | |  | | |  | | | |
|  | | | **How to calculate the number of *human doses*** | | | | | | | | | | | | | | | | | |
|  | | | 1. For divided doses such as tablets, capsules, ampoules, patches: 1 tablet, 1 ampoule, 1 patch =1 dose, regardless of strength. For example, 1 fentanyl patch = 1 human dose, 1 ampoule = 1 human dose. | | | | | | | | | | | | | | | | | |
|  | | | 1. For mixtures, calculate the number of doses in the bottle using the information in the following table: | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | **Preparation** | | | | | | **Size of bottles** | | | **Human dose** | | | | **Total doses per bottle** | | |  | | |
|  | | Morphine mixture 2 mg per mL | | | | | | 200 mL | | | 5 mg | | | | 80 | | |  | | |
|  | | Morphine mixture 5 mg per mL | | | | | | 200 mL | | | 5 mg | | | | 200 | | |  | | |
|  | | Oxycodone mixture 1 mg per mL | | | | | | 250mL | | | 5mg | | | | 50 | | |  | | |
|  | | Hydromorphone mixture 1 mg per mL | | | | | | 473mL | | | 2mg | | | | 237 | | |  | | |
|  | | Codeine linctus 5 mg per mL | | | | | | 100mL | | | 5mL | | | | 20 | | |  | | |
| **7.2 Number of human doses of Schedule 8 medicines and drug safe requirements** | | | | | | | | | | | | | | | | | | | | |
|  | | The number of human doses of S8 medicines stored in the drug safe will determine the size of the safe. | | | | | | | | | | | | | | | | | | |
|  | | | | **Number of human doses** | | | **Compliant drug safe** | | | | | **Motion detector** | | | |  | | | | |
|  | | | | ≤ 250 | | | Small | | | | | Not required | | | |  | | | | |
|  | | | | Between 251- 500 | | | Small | | | | | Required | | | |  | | | | |
|  | | | | > 500 | | | Large | | | | | Required | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | |

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| **7.3 Number of Schedule 8 human doses and required drug safe.** Complete Section 7.3 for each dug safe. | | | | | | | | | | | | | | |
|  | Check to confirm the number of doses calculated at 7.1.3 that will be stored in the drug safe identified in Section 7.1.1 | | | | | | | | | | | | | |
|  | ≤ 250: complete Section 7.3.1 | | | | | | | | | | | | | |
|  | 250-500: complete Section 7.3.2 | | | | | | | | | | | | | |
|  | > 500: complete Section 7.3.3 and 7.3.3. a | | | | | | | | | | | | | |
|  | 7.3.1  **≤ 250** human doses will be stored in a small drug safe with no motion detector required. | | | | | | | | | | | | | |
|  |  | Schedule 8 small drug safe make and model number: | | | | | | | | |  | | |  |
|  |  | What is the safe bolted to? | | | | | | | | | | | | |
|  |  |  | | | Concrete floor | | | | Brick wall | | | | | |
|  |  |  | | | Internal wall: what is the safe bolted to?  wall studs  floor joists  steel beam | | | | | | | | | |
|  |  |  | | | Check to confirm the safe is compliant with requirements for a small drug safe as per Appendix A. | | | | | | | | | |
|  |  | Please **attach** photos showing:   * safe with the door closed * safe with the door open, with a ruler held against the door edge to show the thickness of the door plate * how the safe has been bolted into place with four bolts as per Appendix A: Requirements for a small safe | | | | | | | | | | | | |
|  | 7.3.2.  **251- 500** human doses will be stored in small drug safe and monitored by a motion detector device1 | | | | | | | | | | | | | |
|  |  | | | Schedule 8 small drug safe make and model number: | | | | | | | |  | |  |
|  |  | | | What is the safe bolted to? | | | | | | | | | | |
|  |  | | |  | | | Concrete floor | | | Brick wall | | | | |
|  |  | | |  | | | Internal wall: what is the safe bolted to?  wall studs  floor joists  steel beam | | | | | | | |
|  |  | | |  | | | Check to confirm the safe is compliant with requirements for a small drug safe as per Appendix A. | | | | | | | |
|  |  | | |  | | | Check to confirm safe is covered by motion detector linked to continuously monitored alarm system. | | | | | | | |
|  |  | | | Please **attach** photos showing:   * safe with the door closed. * safe with the door open, with a ruler held against the door edge to show the thickness of the door plate * how the safe has been bolted into place with four bolts as per Appendix A. * location of motion detector/s in relation to the drug safe. | | | | | | | | | | |
|  | 7.3.3.  **>500** human doses will be stored in a large safe, continuously monitored by a motion detector device1 | | | | | | | | | | | | | |
|  |  | | | Schedule 8 large drug safe make and model number: | | | | | | | | |  |  |
|  |  | | |  | | Check to confirm the safe is compliant with requirements for a large drug safe as per Appendix B. | | | | | | | | |
|  |  | | |  | | Check to confirm the safe is covered by motion detector linked to continuously monitored alarm system. | | | | | | | | |
|  |  | | | Does the large safe weigh more than one tonne? | | | | | | | | | | |
|  |  | | | Yes | | | | | | | | | | |
|  |  | | | No: check to confirm the safe is mounted on a concrete floor as per requirements listed in Appendix B. | | | | | | | | | | |
|  |  | | | Please **attach** photos showing:   * safe with the door closed * safe with the door open, with a ruler held against the door edge to show the thickness of the door plate * the locking mechanism as per Appendix B * the door is secured with at least 2 locking bolts of at least 32mm * how the safe has been bolted onto a concrete floor as per Appendix B if safe weights less than one tonne * location of motion detector/s in relation to the drug safe. | | | | | | | | | | |
|  | | | 7.3.3. a | | | | | Please **attach** evidence to show the safe was installed by a person licensed under the *Security and Related Activities* *(Control) Act 1996* to install safes. | | | | | | | |
| 1Motion Detectors: drug safe must be covered by movement detector attached to a continuously monitored alarm system | | | | | | | | | | | | | | |

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| **7.4 Access to Schedule 8 medicines** | | | | | | | | | | | | | |
|  |  | | Please check to confirm that only AHPRA registered health practitioners authorised under the *Medicines and Poisons Act 2014* to possess Schedule 8 medicines and employed by the Medical Treatment service will have unsupervised access to S8 medicines and keys/entry codes to storage rooms and drug safes. | | | | | | | | | | |
| **7.5 Record keeping for Schedule 8 medicines** | | | | | | | | | | | | | |
|  | | Check to confirm which type of recording system will be used to record administration or supply of S8 medicines: | | | | | | | | | | | |
|  | | Patient notes **or** | | | | | | | | | | | |
|  | | Other- please describe: | | | | |  | | | | | |  |
|  | | Which type of drug register will be used to record the receival of and administration or supply of S8 medicines1 | | | | | | | | | | | |
|  | | Paper Schedule 8 register – HA14 **OR** | | | | | | | | | | | |
|  | | Department of Health approved Electronic Schedule 8 register | | | | | | | | | | | |
|  | | Name of approved electronic register: | | | | | | |  | | |  | |
|  | | Check to confirm records of administration or supply and registers will be kept for a minimum of 5 years1 | | | | | | | | | | | |
| **7.6 Inventory, loss, theft and discrepancies of Schedule 8 medicines** | | | | | | | | | | | | | |
|  | | Check to confirm an inventory (balance check) of S8 medicines will be conducted at least monthly2. | | | | | | | | | | | |
|  | | Check to confirm any discrepancies that have not been accounted for are reported to MPRB ASAP2 | | | | | | | | | | | |
|  | | Check to confirm loss / theft of S8 medicines will be reported to MPRB and police ASAP3 | | | | | | | | | | | |
| **7.7 Disposal/destruction of Schedule 8 medicines** | | | | | | | | | | | | | |
|  | 7.7.1  Check to confirm an inventory of S8 medicines will be conducted prior to being disposed of or destroyed. | | | | | | | | | | | | |
|  | 7.7.2 Please indicate how expired or substandard Schedule 8 medicines will be disposed of: | | | | | | | | | | | | |
|  | | | |  | Returned to Permit holder, only if the Permit holder is a medical practitioner and **not** a corporation or partnership | | | | | | | | |
|  | | | |  | **or** | | | | | | | | |
|  | | | |  | Returned to wholesaler for disposal | | | | | | | | |
|  | | | |  | Name of wholesaler: | | |  | | |  | | |
|  | | | |  | **or** | | | | | | | | |
|  | | | |  | *Destroyed* at the site, placed into a sharp’s container, collected by a licensed clinical waste disposal serviceand incinerated4 | | | | | | | | |
|  | | | |  | Name of licensed clinical waste disposal service: | | | | |  |  | | |
|  | | | |  | Please confirm the following: | | | | | | | | |
|  | | | | |  | Schedule **8** medicines will be *destroyed* by making them unidentifiable and unusable4 | | | | | | | |
|  | | | | |  | destruction will be **conducted** by persons authorised by Medicines and Poisons Regulations 20164,5 | | | | | | | |
|  | | | | |  | destruction will be **witnessed** by persons authorised by Medicines and Poisons Regulations 20164,5 | | | | | | | |
| 1 [Schedule 8 drug registers](https://ww2.health.wa.gov.au/Articles/S_T/Schedule-8-drug-registers)  2 [Recording of Schedule 8 transactions in an approved register](https://ww2.health.wa.gov.au/Articles/N_R/Recording-S8-and-S9-transactions)  3 [Reporting loss or theft of medicines and poisons](https://ww2.health.wa.gov.au/Articles/N_R/Reporting-loss-or-theft-of-medicines-and-poisons)  4 [Disposal of medicines](https://ww2.health.wa.gov.au/Articles/A_E/Disposal-of-medicines)  5 Persons authorised to destroy S8 medicines and witnesses include health professionals such as medical practitioners, registered nurses, pharmacists, paramedics and must be two different people. | | | | | | | | | | | | | |
| Section 7 continues next page | | | | | | | | | | | | | |

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| **7.8 Administration and supply of Schedule 8 medicines to patients** | | | | | |
|  | | Which type of health practitioner will be authorising administration and supply of Schedule 8 medicines to patients | | | |
|  | | 7.8.1  **Medical Practitioner** | | | |
|  | | | 1. ***Administration*** of **Schedule 8** medicines (please check ONE option only): | | |
|  | | | |  | Doses of Schedule 8 medicines will only be *administered* by the medical practitioner or in accordance with a direction by a medical practitioner for each individual patient **OR** |
|  | | | |  | A combination of individual directions to *administer* and Structured Administration and Supply Arrangements (SASAs)1, will be used for *administration* of doses of Schedule 8 medicines **OR** |
|  | | | |  | All *administration* of doses of Schedule 8 will be in accordance with a SASA1 |
|  | | | 1. ***Supply*** of **Schedule 8** medicines for patients to take away(please check ONEoption only): | | |
|  | | | |  | Schedule 8 medicines will not be *supplied* to patients to take away **OR** |
|  | | | |  | All Schedule 8 medicines for patients to take away will be personally *supplied* by a medical practitioner: complete Section 7.9 |
|  | | | | 1Note: Structured Administration and Supply Arrangements (SASA’s) can only be written:   * and approved by a medical practitioner and not a nurse practitioner. * for acute conditions or a public health issue * for the administration and not the supply of Schedule 8 medicines.   Information on SASAs are available at: [Structured Administration and Supply Arrangements](https://ww2.health.wa.gov.au/Articles/S_T/Structured-Administration-and-Supply-Arrangements)  Once completed, copies of SASAs must be forwarded to the Medicines and Poisons Regulation Branch.  Completion of SASAs is not required as part of the Permit application process. | |
|  | 7.8.2  **Nurse Practitioner** | | | | |
|  | | | 1. ***Administration*** of **Schedule 8** medicines | | |
|  | | | |  | Check to confirm that doses of Schedule 8 medicines will only be *administered* by a nurse practitioner or *in* accordance with a direction by a nurse practitioner for each individual patient. |
|  | | | 1. ***Supply*** of **Schedule 8** medicines for patients to take away (please check ONE option only): | | |
|  | | | |  | Schedule 8 medicines will not be *supplied* to patients to take away **OR** |
|  | | | |  | All Schedule 8 medicines for patients to take away will be personally *supplied* by a nurse practitioner: complete Section 7.9 |
| **7.9 Supplying Schedule 8 medicines to patients** | | | | | |
|  | Complete Section 7.9 only if Schedule 8 medicines will be supplied to patients to take away by a medical practitioner or nurse practitioner only. | | | | |
|  | Please check to confirm Schedule 8 medicines supplied to patients, will be labelled according to Appendix L of the  [Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)](https://www.tga.gov.au/publication/poisons-standard-susmp) | | | | |
|  | More information is found at: [Labels on Medicines and Poisons](https://ww2.health.wa.gov.au/Articles/J_M/Labels-on-medicines-and-poisons) and [Code of Practice for Health Service Permits for Medical Treatment](http://ww2.health.wa.gov.au/Articles/N_R/Providing-medicines-for-employees-at-remote-workplaces) | | | | |

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| Auditing | | | |
| Indicate the process/es used to ensure compliance with the legislation and the Code of Practice for Health Service Permits for Medical Treatment: | | | |
|  | Site visits by Permit holders – Frequency: |  |  |
|  | Site visits by other company representative – Frequency: |  |  |
|  | External auditing – Frequency: |  |  |
|  | Other methods, please specify: | | |
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| **Standard Operating** Procedures (SOP) for medicines management | | |
| Please **confirm** the medical treatment service hasthe following Standard Operating Procedures (SOP): | | |
| **SOP** for **ordering** scheduled medicines, which support the following requirements: | | |
| 1. Orders must be approved by the Permit holder or a registered health practitioner authorised to possess scheduled medicines who has been authorised to approve orders by the Permit holder. If the Permit holder does not personally authorise each order, they must regularly review the medicines being ordered for the business. | | |
| 1. Only medical practitioners, nurse practitioners, registered nurses, enrolled nurses, registered paramedics or medics should receive medicines when delivered by wholesalers. Other staff such as administration staff cannot be designated as responsible for this task. | | |
| 1. Scheduled medicines must be ordered from a licensed pharmaceutical wholesaler. | | |
| Please check the box to confirm that orders will be sent directly to the site by the wholesaler. | | |
| **If** orders are not sent directly to the site by the wholesaler, explain why and describe the alternative arrangement used: | | |
|  |  |  |
|  |  |  |
|  | | |
| **SOP** for **recording** administration and supply of medicines, which support the following requirements: | | |
| 1. When a direction is given by telephone or other electronic means by a prescriber, an entry is made into the patients’ clinical record by the prescriber within 24 hours of giving the direction. | | |
| 1. All medicines administered or supplied (only medicines in Schedule 2, 3 and 4 can be supplied) are recorded in the patients’ medical notes. | | |
| 1. All schedule 8 medicines that are administered are also recorded in the Paper Schedule 8 register – HA14 or Department of Health approved Electronic Schedule 8 register. | | |
| 1. A record of the administration or supply of a medicine in Schedule 4 is kept for a minimum of 2 years. | | |
| 1. A record of the administration of a medicine in Schedule 8 is kept for a minimum of 5 years | | |
|  | | |
| **SOP** for **labelling** Schedule 2, 3 and 4 medicines for supply, which support the following requirements: | | |
| 1. A medicine in Schedule 2 or 3 is only supplied in the manufactures original pack. | | |
| 1. A medicine in Schedule 4 must be labelled for the individual patient in compliance with the Medicines and Poisons Regulations 2016. See Code of practice for Health Service Permits for Medical Treatment for details. | | |
| **SOP** for checking and recording an **inventory** of Schedule 8 medicines (if Schedule 8 medicines will be stored). SOP must support the following requirements: | | |
| 1. Completed by Permit holder or appropriate person delegated in writing by the Permit holder. | | |
| 1. Inventory for medicines in Schedule 8 will be performed at least monthly and whenever the on-site person responsible for the S8 medicines changes. | | |
| 1. Includes: date inventory is made, name, quantity and strength of S8, signed. | | |
|  | | |
| **SOP** for **investigating** and **reporting loss** or **theft** of **Schedule 4** or **8** medicines to Permit holder and WA  Department of Health, which support the following requirements: | | |
| 1. Notifying Department of Health if loss or theft involves medicines in Schedule 4 or 8. | | |
| 1. WA police notified immediately if it appears that Schedule 8 medicines have been stolen. | | |
| 1. Notifying the Permit holder. | | |
| 1. Reporting is completed by Permit holder or appropriate person delegated in writing by the Permit holder. | | |
| For more information, visit: [Reporting loss or theft of medicines and poisons](https://ww2.health.wa.gov.au/Articles/N_R/Reporting-loss-or-theft-of-medicines-and-poisons) | | |
|  | | |
| Section 9 continues next page | | |

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| **SOP** for checking and **managing expired** and/or **substandard** medicines which support the following requirements: |
| 1. Completed by Permit holder or delegated by Permit holder in writing to appropriate staff. |
| 1. Stocktakes are undertaken regularly, and short dated stock flagged |
| * + For Medicines in Schedule 2, 3 and 4   + Expired and damaged stock are isolated and labelled so they are not used   + Returned to Permit holder or placed in a drug waste container which is taken by controlled waste management contractor for incineration. |
| 1. For medicines in Schedule 8 (if Schedule 8 medicines are required):    * Stock is isolated and labelled for destruction    * Returned to Permit holder or kept in safe until an authorised person is available to witness destruction.    * If destroyed at site:      + Destroyed by making medicine unidentifiable and chemically or physically unusable.      + Transfer to drug waste bin and taken by controlled waste management contractor for incineration OR      + Only placed in sharps container, if it is certain that it is incinerated.    * Written out of register when returned to Permit holder or destroyed. |
| For more information please visit: [Disposal of medicines](https://ww2.health.wa.gov.au/Articles/A_E/Disposal-of-medicines) |
|  |
| **SOP** for **implementing** a pharmaceutical sponsor or supplier consumer level **product recall**. SOP must support the following requirements: |
| 1. Recall notice checked against stock and affected stock quarantined and labelled appropriately |
| 1. Incoming stock is monitored. |
| 1. Checking if recalled medications have been supplied and request, they be returned. |

|  |  |
| --- | --- |
| Multiple sites | |
| Will medicines be stored at multiple sites under this Permit? | |
| No | |
| Yes: complete Sections 10.1 and 10,2 | |
| 10.1 Will the responsible person for the other sites be the same as the individual Permit holder, i.e. medical practitioner or a person responsible for the site named in Section 3.1? | |
|  | Yes |
|  | No: Complete and **attach** Part 3: Personal Information: Identification, Fitness for the nominated responsible person for the other sites. |
| 10.2 Will responses to Sections 4,6,8 and 9 be the same for the other sites as for the site named in Section 3.1 | |
|  | Yes: Complete and **attach** Section 3,5 and Section 7 (if storing S8 medicines) for all other sites. |
|  | No: Complete and **attach** Sections 3,4,5,6,8,9 and Section 7 (if storing S8 medicines) for all other sites. |
|  | |

**Part 1: Application for a Medical Treatment Permit**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Declaration by applicant to obtain a Permit | | | | | | | | | | | | |
| This declaration relates to the application itself and must be signed by the individual applicant (medical practitioner) or if the Permit is being issued to a corporation or partnership, the declaration must be signed by one of the corporate officers or partners.  Please refer to Instruction 8 for information on acceptable signatures. | | | | | | | | | | | | |
| I (provide full name): | | | |  | | | | | | |  | |
| of (provide full address): | | | |  | | | | | | |  | |
| hereby declare: | | | | | | | | | | | | |
|  | | The information contained in this application form is true and correct. | | | | | | | | | | |
|  | | I am aware that penalties apply under the *Medicines and Poisons Act 2014* for providing false or misleading information in this application. | | | | | | | | | | |
| Signature of applicant: | | |  | | | | | Date: |  | | |  |
| **Witnessed by:** | | | | | | | | | | | | |
|  |  | | | |  |  | | | |  | | |
| (Signature of Witness) | | | | | | | (Name of Witness) | | | | | |

|  |
| --- |
| PART 2: PERSONAL INFORMATION: APPLICANT |

**Part 2** assesses identification, fitness and probity of the Permit holder.

If the Permit holder is an individual medical practitioner,all sections of Part 2 must be completed.

If the Permit holder is a corporation or partnership all sections of Part 2 except Section 13 must be completed by each corporate officer or each partner.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Identification of applicant | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Refer to instruction number 2, for information on the requirements for being a Permit holder. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **12.1 Personal Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title: | |  | | | Forename/s: | | | | |  | | | Surname: | | | | |  | | | | Date of birth: | | | |  | | |  |
| Address: | | | |  | | | | | | | | Suburb: | | | |  | | | | | | | Postcode: | | | |  | |  |
| Postal address: | | | | | |  | | | | | | | | Suburb: | | |  | | | | | | | Postcode: | | | |  |  |
| Mobile number: | | | | | | |  | | | | | | | | Email: | | | |  | | | | | | | | | |  |
| Position in business: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  |
| **12.2 Certified true copy of a photographic identification document** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ATTACH** a certified 1 copy of a WA State Government or Australian Government issued photographic identification document such as drivers’ licence or passport. Non-government issued identification documents will not be accepted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1Copy of photographic identification document must be certified as a true copy by a person authorised to witness statutory declarations (see Appendix C for a list of persons authorised to certify a true copy). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **12.3 Role in relation to Permit** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | The individual medical practitioner who will hold the Permit on behalf of the business. Complete remainder of Part 2. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | A corporate officer: only applicable if the Permit will be issued to a body corporate. Type of corporate officer: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | Director | | | | | | General Manager | | Company secretary | | | | | | | | | CEO | CFO | | | | COO | | | | | |
|  |  | | Complete Sections 14,15,16 and 17 in Part 2 and **attach** a CV1 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | A partner: only applicable if the Permit will be issued to a partnership | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | Complete Sections 14,15,16 and 17 in Part 2 and **attach** a CV1 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | 1The CV will be used to assess whether each corporate officer or partner meets the requirements of the *Medicines and Poisons ACT 2014.* | | | | | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Qualifications of applicant applying as an individual person | | | | | | |
| Complete this section if you are a medical practitioner applying for a Permit on behalf of a business.  Do not complete this section, if the Permit is being issued to a corporation or partnership. | | | | | | |
| Refer to instruction number 2 for information on the requirements for being an individual Permit holder. | | | | | | |
| AHPRA registration number: | | |  | Registration expiry date: |  |  |
| **13.1 Attach** a copy of your currentannual registration certificate or wallet card provided to you by AHPRA.  Note: please **do not** provide an extract of the information available on AHPRA’s public website. | | | | | | |
| **13.2 Access to medicines and authority within the business** | | | | | | |
|  |  | Please check to confirm you will always have access to the medicines stored at the sites listed on the Permit. | | | | |
|  |  | Please check to confirm you will have authority within the Medical Treatment service to determine policies and procedures in relation to managing the medicines listed on the Permit. | | | | |
|  | | | | | | |

**Part 2: Personal Information: Applicant**

|  |  |  |
| --- | --- | --- |
| Prior licences/permits for medicines/poisons held by applicant | | |
| To be completed by the nominated individual Permit holder, each corporate officer or each partner. | | |
| **14.1** | Have you (or a company of which you were a corporate officer or a partner) previously held a Licence or Permit, under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory, that was suspended or cancelled? | |
|  | No | |
|  | Yes: please provide details of the Licence or Permit number, the name of the business, when the cancellation or suspension occurred, the reason for the cancellation or suspension and which state or territory the cancellation or suspension occurred in: | |
|  |  |  |
|  |  |  |
|  | | |
| **14.2** | Have you (or a company of which you were a corporate officer) ever been refused a Permit or Licence under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory? | |
|  | No | |
|  | Yes: please provide details of the name of the business, what type of Licence or Permit you applied for, why your application was refused and which state or territory the refusal occurred in: | |
|  |  |  |
|  |  |  |
|  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Criminal **check** for applicant | | | | |
| **15.1** | **Offences under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory.** | | | |
|  | Have you ever been convicted of or are there charges pending for an offence under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory? | | | |
|  | No | | | |
|  | Yes: you must **attach** full details in the form of a Statutory Declaration. Your declaration must include the:   * Name of the court including state/territory or country, all relevant dates and any sentences received * The nature of the alleged offence and circumstances surrounding the offences | | | |
| **15.2** | **Indictable offences1** | | | |
|  | Role in relation to the Permit: | | | |
|  | * 1. individual medical practitioner | | | |
|  |  | Have you been convicted of, or are there charges pending for indictable1 offences since you last applied for renewal of your registration as a health practitioner? | | |
|  |  | No | | |
|  |  | Yes: please **attach** full details in the form of a Statutory Declaration and include the:   * Name of court including state/territory/ country, relevant dates and any sentences received * The nature of the alleged offence and circumstances surrounding the offences. | | |
|  | | | | |
|  | b.  a corporate officer or partner. | | | |
|  |  | | i **Attach** a copy of your National Police Clearance certificate (NPC) which is less than 12 months old**.** | |
|  |  | | ii Have you been convicted of, or are charges pending for indictable1 offences since the date on your NPC? | |
|  |  | | | No |
|  |  | | | Yes: you must **attach** full details in the form of a Statutory Declaration. Your declaration must include:   * Name of court including state/territory or country, relevant dates and any sentences received * The nature of the alleged offence and circumstances surrounding the offences. |
|  | 1 Minor traffic offences are not classified as indictable offences | | | |

**Part 2: Personal Information: Applicant**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Financial resources of applicant | | | | | |
| To be completed by the nominated individual Permit holder, each corporate officer or each partner. | | | | | |
| **16.1** | Have you been declared bankrupt or a debtor under any bankruptcy law? | | | | |
|  | No | | | | |
|  | Yes: What date was/will your bankruptcy be discharged? |  | |  | |
| **16.2** | Have you ever been a corporate officer of a company that was wound up or subject to an application for, or placed in, receivership or liquidation? | | Yes | | No |
|  | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Declaration by applicant | | | | | | | |
| This declaration must be signed by the applicant: individual medical practitioner, each corporate officer or each partner and includes probity check consent.  Please refer to Instruction 8 for information on acceptable signatures. | | | | | | | |
|  | In accordance with Section 39 of the *Medicines and Poisons Act 2014*, I give consent to the Western Australian Department of Health to carry out all relevant searches to determine my fitness and probity in relation to holding a Medical Treatment Permit. These searches may include (without limitation) corporate searches, checks with health professional registration boards (including registration status and release of information on any current or ongoing investigations) and criminal record checks. I also understand I may be requested to provide further information relevant to determining fitness and probity. | | | | | | |
|  | I am at least 21 years of age. | | | | | | |
|  | The information contained in this application form is true and correct. | | | | | | |
|  | I am aware there are penalties under the *Medicines and Poisons Act 2014* for providing false or misleading information. | | | | | | |
|  | I am aware of my responsibility for the safe storage and use of medicines and will ensure compliance with the *Medicines and Poisons Act 2014* and Medicines and Poisons Regulations 2016, and compliance with conditions placed on the Permit. | | | | | | |
|  | I will notify the Department of Health if I am no longer employed by the Medical Treatment provider, a corporate officer (if the applicant is a corporation) or a partner (if the applicant is a partnership). | | | | | | |
| Signature: | |  | Name: |  | Date: |  |  |
|  | | | | | | | |

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| --- |
| PART 3: PERSONAL INFORMATION: RESPONSIBLE PERSON |

**Part 3** must be completed by the responsible person and assesses identification, fitness and probity.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Identification of responsible person | | | | | | | | | | | | | | | | | | | | | | | |
| The role of the responsible person is to manage the medicines on a day to day basis and be the contact person, if the Permit holder is not available. | | | | | | | | | | | | | | | | | | | | | | | |
| Refer to instruction number 3, for information on the requirements for being responsible for a site. | | | | | | | | | | | | | | | | | | | | | | | |
| **18.1** Will the individual medical practitioner applying to be Permit holder, also be responsible for the sites named in Section 3.1? | | | | | | | | | | | | | | | | | | | | | | | |
| Yes: Confirm name: | | | | | | | | Forename/s: | |  | | | | | | | Surname: |  | | | | |  |
|  | | | There is no requirement to complete Part 3 | | | | | | | | | | | | | | | | | | | | |
| No: complete remainder of Part 3. | | | | | | | | | | | | | | | | | | | | | | | |
| **18.2 Personal Details of responsible person** | | | | | | | | | | | | | | | | | | | | | | | |
|  | Dr. | | | Forename/s: | | |  | | | | Surname: | | | |  | | | | Date of birth: | | |  |  |
|  | Postal Address: | | | |  | | | | | | | Suburb: | |  | | | | | | Postcode: |  | |  |
|  | Mobile number: | | | | |  | | | | | | | Email: | | |  | | | | | | |  |
|  | Position in business: | | | | | | | |  | | | | | | | | | | | | | |  |
| **18.3 Certifiedtrue copy of a photographic identification document** | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **ATTACH** a certified1 copy of a WA State Government or Australian Government issued photographic identification document such as drivers’ licence or passport. Non-government issued identification documents will not be accepted. | | | | | | | | | | | | | | | | | | | | | |
|  | | 1Copy of photographic identification document must be certified as a true copy by a person authorised to witness statutory declarations (see Appendix C for a list of persons authorised to certify a true copy). | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Quali**fications of person responsible for a site | | | | |
| **AHPRA registration number**: |  | Registration expiry date: |  |  |
| **Attach** a copy of your currentannual registration certificate or wallet card provided to you by AHPRA.  Note: please **do not** provide an extract of the information available on AHPRA’s public website | | | | |

**Part 3: Personal Information: Responsible Person**

|  |  |  |
| --- | --- | --- |
| Prior licences/permits for medicines/poisons held by responsible person | | |
| **20.1** | Have you (or a company of which you were a corporate officer or a partner) previously held a Permit or Licence under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory, that was suspended or cancelled? | |
|  | No | |
|  | Yes: please provide details of the Licence or Permit number, the name of the business, when the cancellation or suspension occurred, the reason for the cancellation or suspension and which state or territory the cancellation or suspension occurred in: | |
|  |  |  |
|  |  |  |
|  |  |  |
|  | | |
| **20.2** | Have you (or a company of which you were a corporate officer) ever been refused a Permit or Licence under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory? | |
|  | No | |
|  | Yes: please provide details of the name of the business, what type of Permit or Licence you applied for, why your application was refused and which state or territory the refusal occurred in: | |
|  |  |  |
|  |  |  |
|  |  |  |
|  | | |

|  |  |
| --- | --- |
| Criminal check for responsible person | |
| **21.1** | **Offences under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory.** |
|  | Have you ever been convicted of or are there charges pending for an offence under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory. |
|  | No |
|  | Yes: you must **attach** full details in the form of a Statutory Declaration. Your declaration must include the:   * Name of the court including state/territory or country, all relevant dates and any sentences received * The nature of the alleged offence and circumstances surrounding the offences |
| **21.2** | **Indictable offences** |
|  | Have you been convicted of or are there charges pending for indictable1 offences since you last applied for renewal of your registration as a health practitioner? |
|  | No |
|  | Yes: you must **attach** full details in the form of a Statutory Declaration. Your declaration must include the:   * Name of the court including state/territory or country, all relevant dates and any sentences received * The nature of the alleged offence and circumstances surrounding the offences |
|  | 1 Minor traffic offences are not classified as indictable offences |
|  | |

**Part 3: Personal Information: Responsible Person**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Declaration by nominated responsible person | | | | | | |
| This declaration must be signed by the nominated responsible person and includes probity check consent.  Please refer to Instruction 8 for information on acceptable signatures. | | | | | | |
| 1. I acknowledge my role is to manage the medicines on a day to day basis and be the contact person, if the Permit holder is not available. | | | | | | |
| 1. I give consent to the Western Australian Department of Health to carry out all relevant searches to determine my fitness and probity to be named as the responsible person on a Medical Treatment Permit. These searches may include (without limitation) corporate searches, and criminal record checks. I also understand I may be requested to provide further information relevant to determining fitness and probity. | | | | | | |
| 1. I am at least 21 years of age. | | | | | | |
| 1. The information contained in this application form is true and correct. | | | | | | |
| Signature: |  | Name: |  | Date: |  |  |
|  | | | | | | |

# 

# PART 4: PAYMENT and CHECKLIST

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Payment | | | | | | | | | | | | | | | | | | |
| **Fee: $370** | | | | | | | | | | | | | | | | | | |
| Comprising a non-refundable application fee of $212 and 1 year Permit fee of $158.  Permit fee only will be refunded if the Permit is not issued. | | | | | | | | | | | | | | | | | | |
| * + 1. Credit Card – American Express and Diners not accepted | | | | | | | | | | | | | | | | | | |
|  | Card type: | | MasterCard | | | | | Visa | | | | | | | | | | |
|  | Name on card: |  | | | | | | | | Card number: |  | | | | | | |  |
|  | Expiry date: |  | | | | | Amount:  **$370** | | | | | | | | | | | |
|  | Signature of cardholder: | | | |  | | | | | | | | | Date: | |  |  | |
|  | | | | | | | | | | | | | | | | | | |
| * + 1. Direct debit to bank | | | | | | | | | | | | | | | | | | |
|  | **Please quote applicant’s name or business name in the reference** | | | | | | | | | | | | | | | | | |
|  | Bank: Commonwealth Bank: | | | | | **BSB**: 066 040 | | | **Account number:** 13300018 | | | | Amount: **$370** | | | | | |
|  | Receipt Number: | | |  | | | | | | | | Payment date: | | |  | |  | |
|  | | | | | | | | | | | | | | | | | | |
| * + 1. Cheque or money order – made payable to DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | |

**Please keep a copy of the completed application form for reference**

Please email completed form and other requested documentation to [mprb@health.wa.gov.au](mailto:mprb@health.wa.gov.au)

Please email completed form and other requested documentation to: [mprb@health.wa.gov.au](mailto:mprb@health.wa.gov.au)

**PART 4: PAYMENT and CHECKLIST**

|  |  |
| --- | --- |
| Checklist | |
| Please ensure all the appropriate requested documentation is attached for: | |
| **Part 1 Application for a Medical Treatment Permit** | |
|  | If the Permit is being issued to a corporation, attach a copy of the Current Company Extract from ASIC (with details of all company directors and secretary (Section 1.2.1) |
|  | If the business has a Business or Trading Name, attach a copy of certificate of Record of Registration for Business Name or Current Business Name Extract (Section 1.3) |
|  | Completed Part 3 Personal Information: Identification, Fitness and Probity for responsible person **if** different from the Permit holder (Section 3.3) |
|  | If storing Schedule 8 medicines, photos of safe etc as required in Section 7.3 |
|  | If storing S8 medicines in a large safe, evidence to show the safe was installed by a person licensed under the *Security and Related Activities* *(Control) Act 1996* to install safes. (Section 7.3.3.a) |
|  | Copy of relevant sections if there are multiple sites (Section 10) |
|  | Declaration signed and dated by **applicant** (nominated Permit holder)and witnessed (Section 11) |
| **Part 2: Personal information, fitness and probity for applicant (nominated Permit holder) i.e.**  **Individual applicant, each corporate officer or each partner** | |
|  | Copy of photographic identification which must be certified as a true copy (Section 12.2). See Appendix C for a list of persons authorised to certify a true copy. |
|  | If the applicant is a corporation or partnership, attach a CV and copies of qualifications for each corporate officer or partner (Section 12.3) |
|  | If the applicant is an individual medical practitioner, attach the currentannual registration certificate or wallet card provided by AHPRA. **Do not** provide an extract of information available on AHPRA’s public website. (Section 13.1) |
|  | If applicable, a Statutory Declaration relating to an offence under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory (Section 15.1) |
|  | If the applicant is an individual medical practitioner, and they have been convicted of or there are charges pending for an indictable offence since they last renewed their registration, attach a Statutory Declaration relating to the offence (Section 15.2. a) |
|  | If the applicant is a corporation or partnership, attach a copy of the NPC for each corporate officer or partner which is less than 12 months old (Section 15.2.b i) |
|  | If the applicant is a corporation/partnership and a corporate officer/partner has been convicted of, or there are charges pending for an indictable offence since the date on their NPC, attach a Statutory Declaration relating to the offence (Section 15.2.b ii) |
|  | Declaration about personal information of applicant signed by applicant (Section 17) |
| **Part 3: Personal information, fitness and probity for responsible person** | |
|  | Copy of photographic identification which must be certified as a true copy. (Section 18.3)  See Appendix C for a list of persons authorised to certify a true copy. |
|  | Copy of the responsible person’s current annual registration certificate or wallet card provided by AHPRA.  **Do not** provide an extract of the information available on AHPRA’s public website. (Section 19.2) |
|  | If applicable, a Statutory Declaration relating to an offence under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory (Section 21.1) |
|  | If the responsible person has been convicted of or there are charges pending for an indictable offence since they last renewed their registration, attach a Statutory Declaration relating to the offence (Section 21.2) |
|  | Declaration about personal information of responsible person signed and dated (Section 22) |
| **Part 4: Declaration and Payment** | |
|  | Payment details completed with correct signature **if** paying by credit card (Section 23) |

# PART 5: APPENDICES

## Appendix A: Requirements for a small safe

The requirements for a small drug safe are set out in the Table.

**Table**

|  | Requirements |
| --- | --- |
| **Cabinet/body** | Must be made from solid steel plate at least 10 mm thick or a steel skin with concrete fill at least 50 mm thick  All joints must be continuously welded |
| **Door** | Must be made from solid steel plate at least 10 mm thick or a steel skin with concrete fill at least 50 mm thick  Must be fitted flush to the cabinet/body with a maximum clearance of 1.5 mm when closed  Hinge system must be a system that does not allow the door to be opened if the hinge is removed |
| **Lock** | Must be a 6 lever key lock or a 4 wheel combination lock or a digital lock that provides security that is equivalent to a 6 lever key lock or 4 wheel combination lock |
| **Mounting** | Must be mounted on a concrete floor or a brick or concrete wall with at least 4 expanding bolts of at least 12 mm in diameter  If mounting on a concrete floor or a brick or concrete wall is not possible must be securely mounted on structural elements of the building such as studs or floor joists |

**PART 5: APPENDICES**

## Appendix B: Requirements for a large safe

The requirements for a large safe are set out in the Table.

**Table**

|  | **Requirements** |
| --- | --- |
| **Cabinet/body** | Must be made from solid steel plate at least 10 mm thick or a steel skin with concrete fill at least 50 mm thick  All joints must be continuously welded |
| **Door** | Must be made from solid steel plate at least 10 mm thick or a steel skin with concrete fill at least 50 mm thick  Must be fitted flush to the cabinet/body with a maximum clearance of 1.5 mm when closed  Hinge system must be a system that does not allow the door to be opened if the hinge is removed  Must be secured with at least 2 locking bolts of at least 32 mm diameter |
| **Lock** | Must be a 6 lever key lock or a 4 wheel combination lock or a digital lock that provides security that is equivalent to a 6 lever key lock or 4 wheel combination lock |
| **Mounting** | Must be mounted on a concrete floor with an expanding bolt with a diameter of at least 16 mm unless the safe weighs more than 1 tonne |
| **Installation** | Must be installed by a person licensed under the *Security and Related Activities (Control) Act 1996* to install safes |
| **Weight** | Must have a minimum weight of 250 kg |

**PART 5: APPENDICES**

## Appendix C: Certifying true copies of photographic identification

Suggested wording for certification is as follows:

I certify that this appears to be a true copy of the document produced to me on <date>

Signature

Name

Profession or occupation group

| **Persons who can certify documents** | |
| --- | --- |
| Academic (tertiary institution) | Medical practitioner |
| Accountant | Member of Parliament |
| Architect | Minister of religion |
| Australian Consular Officer | Nurse |
| Australian Diplomatic Officer | Optometrist |
| Bailiff | Patent attorney |
| Bank manager | Pharmacist |
| Chartered secretary | Physiotherapist |
| Chiropractor | Podiatrist |
| Company auditor or liquidator | Police officer |
| Court officer (judge, master, magistrate, registrar or clerk) | Post Office manager |
| Defence Force officer | Psychologist |
| Dentist | Public servant |
| Engineer | Public notary |
| Industrial organisation secretary | Real Estate agent |
| Insurance broker | Settlement agent |
| Justice of the Peace | Sheriff or deputy Sheriff |
| Lawyer | Surveyor |
| Local government CEO or deputy CEO | Teacher |
| Local government councillor | Tribunal officer |
| Loss adjuster | Veterinarian |
| Marriage celebrant |  |