Residential Care Permit

Application Form

*Medicines and Poisons Act 2014*

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| INSTRUCTIONS and INFORMATION |
|  | This application form is for a new **Residential Care Permit** for a residential care facility to obtain medicines for imprest stock for the treatment of residents of the facility.A permit is not required if the only medicines that are stored at the facility will be prescribed by a prescriber and dispensed by a pharmacist for each individual resident. Once a medicine has been prescribed and dispensed, the Western Australian Medicines and Poisons legislation has been fully applied.However, the Medicines and Poisons legislation does apply to imprest stock which has been supplied to the facility to store in case a resident may require one or two doses, for example medicines such as morphine injection.Please note all new Permits are issued with a condition that vaccines in Schedule 4 can also be purchased for administration to staff of the facility.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 understands 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 Residential Care 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 Residential Care Permit.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 applicants **(medical practitioner, nurse practitioner or registered nurse only**)who:
* must complete Part 2: Personal Information: Identification, Fitness and Probity and sign the declaration at Section 15.
* must be an AHPRA registered medical practitioner, nurse practitioner or registered nurse
* must have authority within the business to determine policies and procedures in relation to handling and managing the imprest medicines on the Permit.

**or**1. Body corporate (corporation) or partnership and:
	* each corporate officer (directors, company secretary, chief executive officer, 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 15.
	* 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 or Clinical Director i.e. medical practitioner, nurse practitioner or registered nurseregistered with AHPRA, who is:* the most senior person responsible for provision of medical care and
* must have authority within the business to determine policies and procedures in relation to managing imprest 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 facility 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 medicines at a facility**An individual person must also be nominated to have overall responsibility for each facility included on the Permit. The role of the responsible person is to manage the imprest medicines on a day to day basis and be the contact person if the Permit holder is not available. The responsible person for a facility must:* be employed or contracted by the Permit holder
* reside in WA
* be the senior medical practitioner, nurse practitioner, registered nurse or enrolled nurse at the facility. See 3.1 and 3.2 for other options.
* complete Part 3: Personal Information: Identification, Fitness and Probity
* sign the declaration at Section 20.

**3.1 Responsible person for a Permit issued to an individual person:**The responsible person for a facility when a Permit is issued to an individual person can be:1. the individual Permit holder, only if the Permit is issued to an individual medical practitioner, nurse practitioner or registered nurse and not a corporation or partnership.

 **or**1. the most senior medical practitioner, nurse practitioner, registered nurse or enrolled nurse at the facility

 **3.2 Responsible person for a Permit issued to a corporation or partnership**The responsible person for a facility when a Permit is issued to a corporation or partnership can be:1. the most senior medical practitioner, nurse practitioner or registered nurse at the facility.

 **or** 1. the Medical Director or Clinical 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 imprest medicines at every facility for which they are responsible. Where a single person is responsible for multiple facilities, the Department may request further information in relation to this capacity. |
|  | **Purchasing a residential care facility** If you are purchasing an existing residential care facility from another residential care business that has a Permit, the current Permit holder must remove this facility from their Permit by completing an Application to Change an existing Residential Care Permit. The application to remove this facility from the other Permit must be received by the Department prior to adding this facility to your Permit. You may have to liaise with the other Residential Care facility so that the change in ownership is coordinated, this ensures the imprest medicines stored at the facility are always covered by a Permit.*The Department does not coordinate the change in Residential Care Permits.* *It is the responsibility of the residential care facility to manage the change in a timely manner.* |

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|  | **Schedule 2, 3, 4 and 8 imprest medicines** The sections relating to required scheduled imprest medicines are divided into two different sections, Sections 4 and 5 relate to storage and use of Schedule of 2,3, and 4 imprest medicines and Section 6 relates to Schedule 8 (Controlled Drug) imprest 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 9 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 Ambulance Service 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 facility inspection,
* Please do not submit your application as a digital image (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 |
| **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 RESIDENTIAL CARE 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 person (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 person** (on behalf of a business) |
|  | Can only be issued to a medical practitioner, nurse practitioner or registered nurse- tick which one applies: |
|  | **[ ]** Medical practitioner | **[ ]** Nurse practitioner | **[ ]** Registered nurse |  |
|  | Title: |        | 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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| Permits issued to a corporation or partnership |
| Is the applicant a corporation or partnership? |
| [ ]  | No, the applicant is an individual medical practitioner, nurse practitioner or registered nurse. |
| [ ]   | Yes: complete Section 2.1 and 2.2 |
| **2.1**  | [ ]  Check to confirm the corporation or partnership always employs a Medical Director or Clinical Director i.e., a registered medical practitioner, nurse practitioner or registered nurse who has authority within the business to determine policies and procedures in relation to managing imprest medicines  |
| **2.2** | Details of medical director or clinical director **employed** by the corporation or partnership. |
|  | Title: |       | Forename(s): |       | Surname: |       |  |
|  | Health practitioner type: |
|  | [ ]  Medical practitioner  | [ ]  Nurse practitioner  | [ ]  Registered nurse |
|  | AHPRA registration number: |       | Expiry date: |       |  |
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| Facility and building security details |
| Section 3 must be completed for every facility listed on the Permit. |
| Is this facility being bought from another residential care business? See instruction number 4. |
| [ ]  No  |
| [ ]  Yes: | Name of previous residential care business: |       |  |
|  | The Department requires the previous Permit holder at the relocated or new added facility to remove the facility from their Permit. The application to remove the facility from the previous Permit holder’s Permit must be received by the Department prior to adding the relocated or new added facility to your Permit. |
| **3.1 Facility details** |
|  | Facility name (**if** applicable): |       |  |
|  | Facility address: |       | Suburb:  |       | Postcode:  |       |  |
|  | Telephone: |       | Fax: |       | Email: |       |  |
|  | Date of possession of the facility (settlement date/lease commencement/handover of building): |       |  |
|  | Note: Permit will be issued with “Valid from” date on or after this date |
| **3.2 Person responsible for medicines at the facility**  |
|  | Refer to instruction number 3, for information on the requirements for being responsible for medicines at a facility. |
|  | Details of nominated responsible person for the facility named in Section 3.1  |
|  | Practitioner type: | [ ]  Medical practitioner | [ ]  Nurse practitioner | [ ]  Registered nurse | [ ]  Enrolled nurse |
|  | Title: |       | Forename(s): |       | Surname: |       |  |
|  | The nominated responsible person **must complete Part 3**: Personal Information: Identification, Fitness |
| **3.3 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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| Imprest medicines required, storage, record keeping and access |
| Section 4 must be completed for every facility listed on the Permit |
| Facility address: |       | Suburb: |       | Postcode: |       |  |
| 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 6. |
| **4.1 Please list the Schedule 2,3 and 4 imprest medicines required** |
|

|  |  |
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| **Name, strength and form of medicine** | **Approximate quantity required** |
|       |       |
|       |       |
|       |       |
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| **4.2 Storage and temperature monitoring of Schedule 2, 3, and 4 imprest medicines** |
|  | 4.2.1 | Storage of non- refrigerated imprest medicines in Schedule 2, 3, and 4 (Please check which one applies) |
|  |  | [ ]  Locked room  | [ ]  Locked cupboard |
|  | 4.2.2 | Storage of refrigerated imprest medicines in Schedule 2, 3, and 4 (Please check which one applies) |
|  |  | [ ]  Locked room with refrigerator | [ ]  Locked refrigerator |
|  | 4.2.3 | Temperature monitoring for refrigerated imprest medicines in Schedule 2,3 and 4 |
|  |  | Please indicate how the temperature of refrigerated imprest 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 alarm if the temperature is outside the designated range.
 |
| **4.3 Storage area for Schedule 2,3, and 4 imprest medicines**  |
|  | Please provide information for all areas storing Schedule 2,3 and 4 medicines at the facility: |
|  |

|  |  |
| --- | --- |
| Floor number, room number/room name | Floor number, room number/room name |
|       |       |
|       |       |
|       |       |
|       |       |

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| Section 4 continues next page |

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| **4.4 Record keeping**  |
|  | [ ]  | Check to confirm records of administration of Schedule 4 imprest medicines are maintained in patient’s notes. |
|  | [ ]  | Check to confirm records of administration of Schedule 4 imprest medicines will be kept for at least 2 years |
| **4.5 Access to Schedule 2,3 and 4 imprest medicines** |
| Please indicate who will have access to Schedule 2,3 and 4 imprest medicines at the facility : |
| [ ]  Medical practitioner | [ ]  Nurse practitioner | [ ]  Registered nurse | [ ]  Enrolled nurse |
| [ ]  Other – please describe: |       |  |
|  | **[ ]**  | Please check to confirm that only an AHPRA registered health practitioners authorised under the *Medicines and Poisons Act 2014* to possess Schedule 2,3 and 4 imprest medicines and employed by the residential care facility will have unsupervised access to the imprest medicines and keys/entry codes to storage rooms and refrigerators. |
| **4.6 Preventing access to Schedule 2,3 and 4 imprest medicines** |
|  | Please describe how non-authorised people such as carers, reception staff, cleaners, members of the public (including family members and children) will be prevented from having access to Schedule 2,3 and 4 imprest medicines : |
|  |       |  |
|  |       |  |
| **4.7 Loss or theft of Schedule 4 imprest medicines** |
|  | **[ ]**   | Please check to confirm any loss or theft of Schedule 4 imprest medicines 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) |

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| Administration of Schedule 4 imprest medicines to patients |
| **5.1 Type of health practitioner authorising administration of Schedule 4 imprest medicines to patients** |
|  | 5.1.1 **[ ]  Medical Practitioner** |
|  | 1. ***Administration*** of **Schedule 4 imprest medicines** (please check **ONE** option only):
 |
|  | [ ]  | Doses of **Schedule 4** imprest medicines will be *administered* by a 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 imprest medicines **OR** |
|  | [ ]  | All *administration* of doses of Schedule 4 will be in accordance with a SASA1 |
|  | 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.

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. |
|  | 5.1.2 [ ]  **Nurse Practitioner** |
|  | 1. ***Administration*** of **Schedule 4** imprest medicines
 |
|  | [ ]  | Please check to confirm **Schedule 4** imprest medicines will be *administered* by a nurse practitioner or *in* accordance with a direction by a nurse practitioner for each individual patient**.** |
| Please note: under the Medicines and Poisons Regulations 2016, Schedule 2 and 3 medicines can be administered by any person, however the residential care facility may have their own policy and procedures in relation to the administration of Schedule 2 and 3 medicines. |
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| Schedule 8 imprest medicines |
| Complete Section 6for every facility listed on the Permit which will be storing Schedule 8 imprest medicines. |
| Is this facility being bought from another residential care business? See instruction number 4. |
| [ ]  No |
| [ ]  Yes: | Name of previous residential care business: |       |  |
|  | Are Schedule 8 imprest medicines being transferred from the previous residential care business? |
|  | [ ]  No |
|  | [ ]  Yes: [ ]  please confirm an inventory of S8 imprest medicines will be conducted at the time of handover. |
| Will S8 imprest medicines be stored in multiple areas/rooms at the facility? |
| [ ]  No: complete all of Section 6 |
| [ ]  Yes: complete all of Section 6 for the first drug safe and Sections 6.1 and 6.3 for every other drug safe at the facility. |
| **6.1 Required Schedule 8 imprest medicines**  |
|  | Confirm address of facility:  |       |  |
|  | 6.1.1 Location of drug safe (floor number, room number/name): |       |  |
|  | 6.1.2 Please list all required S8 imprest medicines stored in the drug safe at the location named in Section 6.1.1 |
|  |
|  | Name, strength and form of medicine | Quantity required | Number of *human doses* |  |
|  |       |       |       |  |
|  |       |       |       |  |
|  |       |       |       |  |
|  |       |       |       |  |
|  | 6.1.3 Total number of *human doses* of S8 imprest 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 |  |
| **6.2 Number of human doses of Schedule 8 imprest medicines and drug safe requirements** |
|  | The number of human doses of S8 imprest 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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**Part 1: Application for a Residential Care Permit**

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| **6.3 Number of Schedule 8 human doses and required drug safe.** Complete Section 6.3 for each drug safe. |
|  | Check to confirm the number of doses calculated at 6.1.3 that will be stored in the drug safe identified in Section 6.1.1 |
|  | [ ]  ≤ 250: complete Section 6.3.1 |
|  | [ ]  250-500: complete Section 6.3.2 |
|  | [ ]  > 500 complete: Section 6.3.3 and 6.3.3. a |
| 1.
 | 6.3.1 [ ]  **≤ 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 | [ ]  Other, describe: |       |  |
|  |  | [ ]  | **If** the safe is not bolted to a concrete floor or brick wall, please check to confirm the safe is bolted to a structural element of the building such as a steel beam or floor joist. See Appendix A for information. |
|  |  | [ ]  | 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
 |
|  | 6.3.2 [ ]  **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 | [ ]  Other, describe: |       |  |
|  |  | [ ]  | **If** the safe is not bolted to a concrete floor or brick wall, please check to confirm the safe is bolted to a structural element of the building such as a steel beam or floor joist. See Appendix A for information. |
|  |  | [ ]  | 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 detector1 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.
 |
|  |  6.3.3 [ ]  **>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 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.
 |
|  | 6.3.3. 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  |

**Part 1: Application for a Residential Care Permit**

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| **6.4 Access to Schedule 8 imprest medicines** |
| Please indicate who will have access to Schedule 8 imprest medicines at the facility : |
| [ ]  Medical practitioner | [ ]  Nurse practitioner | [ ]  Registered nurse | [ ]  Enrolled nurse |
| [ ]  Other – please describe: |       |  |
|  | [ ]  | Please check to confirm that only AHPRA registered health practitioners authorised under the *Medicines and Poisons Act 2014* to possess S8 imprest medicines and employed by the residential care facility will have unsupervised access to S8 imprest medicines and keys/entry codes to storage rooms and drug safes. |
| **6.5 Record keeping for Schedule 8 imprest medicines**  |
|  | 1. Check to confirm which type of recording system will be used to record administration of S8 imprest medicines:
 |
|  | [ ]  Patient notes **or**  |
|  | [ ]  Other- please describe: |       |  |
|  | 1. Which type of drug register will be used to record the receival of and administration of S8 imprest 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 and Schedule 8 registers will be kept for a minimum of 5 years1 |
| **6.6 Inventory, loss, theft and discrepancies of Schedule 8 imprest medicines**  |
|  | [ ]  Check to confirm an inventory (balance check) of S8 imprest 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 imprest medicines will be reported to MPRB and police ASAP3 |
| **6.7 Disposal/destruction of Schedule 8 imprest medicines**  |
|  | 6.7.1 [ ]  Check to confirm an inventory of S8 imprest medicines will be conducted prior to being disposed/destroyed. |
|  | 6.7.2 Please indicate how expired or substandard Schedule 8 imprest medicines will be disposed of: |
|  | [ ]  | Taken to a pharmacy or hospital for disposal 4 |
|  |  | Name of pharmacy/hospital: |       |  |
|  |  | **or** |
|  | [ ]  | Returned to wholesaler for disposal |
|  |  | Name of wholesaler: |       |  |
|  |  | **or** |
|  | [ ]  | *Destroyed* at the facility, placed into a suitable clinical and related waste container, collected by a licensed clinical waste disposal serviceand incinerated5 |
|  |  | Name of licensed clinical waste disposal service: |       |  |
|  |  | Please confirm the following: |
|  | [ ]  | Schedule **8** imprest medicines will be *destroyed* by making them unidentifiable and unusable5 |
|  | [ ]  | destruction will be **conducted** by persons authorised by Medicines and Poisons Regulations 20165,6 |
|  | [ ]  | destruction will be **witnessed** by persons authorised by Medicines and Poisons Regulations 20165,6 |
| 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 Pharmacies and hospitals are not obligated to accept medicines for disposal if they have not supplied the medicine5 [Disposal of medicines](https://ww2.health.wa.gov.au/Articles/A_E/Disposal-of-medicines)6 Persons authorised to destroy S8 imprest medicines and witnesses include health professionals such as medical practitioners, registered nurses, pharmacists and must be two different people. |

**Part 1: Application for a Residential Care Permit**

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| **6.8 Administration of Schedule 8 imprest medicines to patients** |
|  | Type of health practitioner authorising administration of Schedule 8 imprest medicines to patients |
|  | 6.8.1 **[ ]  Medical Practitioner** |
|  | 1. ***Administration*** of **Schedule 8** imprest medicines (please check ONE option only):
 |
|  | [ ]  | Doses of Schedule 8 imprest medicines will be *administered* by a medical practitioner or in accordance with a direction by a medical practitioner/nurse practitioner for each individual patient**.** |
|  | [ ]  | 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 imprest medicines. |
|  | [ ]  | All *administration* of doses of Schedule 8 will be in accordance with a SASA1 |
|  | 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

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. |
|  | 6.8.2 [ ]  **Nurse Practitioner** |
|  | 1. ***Administration*** of **Schedule 8** imprest medicines
 |
|  | [ ]  | Please check to confirm Schedule 8 will be *administered* by a nurse practitioner or *in* accordance with a direction by a nurse practitioner for each individual patient. |

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| Standard Operating Procedures (SOP) for imprest medicines  |
| Please **confirm** your residential care facility hasthe following Standard Operating Procedures (SOP) for handling imprest medicines which support the requirements listed: |
| [ ]   | **SOP** for **ordering imprest** medicines. The SOP must support the following requirements: |
| 1. Orders for imprest medicines 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 or enrolled nurses should receive medicines when delivered by wholesalers or the contracted pharmacy. Other staff such as administration staff cannot be designated as responsible for taking delivery of scheduled medicines.
 |
| 1. Name of the pharmacy or wholesaler from which imprest medicines are ordered.
 |
|  |
| [ ]   | **SOP** for **obtaining authorisation** from a prescriber before imprest medicines are administered to a resident. The SOP must support the following requirements: |
| 1. All the details for the administration of imprest medication is entered on the patient’s medication chart and signed by the prescriber OR
 |
| 1. Prescriber authorises administration orally or by telephone or other electronic means and are entered into the Patient’s Medication Chart and signed by the prescriber within 24 hours OR
 |
| 1. Prescriber has authorised administration via a SASA**.**
 |

**Part 1: Application for a Residential Care Permit**

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| Multiple facilities |
| Will medicines be stored at multiple facilities under this Permit?  |
| [ ]  No |
| [ ]  Yes: complete Sections 8.1 and 8.2 |
| 8.1 Will the responsible person for the other facilities be the same as the individual Permit holder or a person responsible for the facility named in Section 3.1? |
|  | [ ]  Yes |
|  | [ ]  No: Complete and **attach** Part 3: Personal Information: Identification, Fitness for the nominated responsible person for the other facilities. |
| 8.2 Will responses to Sections 5 and 7 be the same for the other facilities as for the facility named in Section 3.1  |
|  | [ ]  Yes: Complete and **attach** Section 3, 4 and Section 6 (if storing S8 medicines) for all other facilities. |
|  | [ ]  No: Complete and **attach** Sections 3,4,5,7 and Section 6 (if storing S8 medicines) for all other facilities. |
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| Declaration by applicant to obtain a Permit |
| This declaration relates to the application itself and must be signed by the individual applicant 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 7 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) |

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| PART 2: PERSONAL INFORMATION: APPLICANT |

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

If the Permit holder is an individual health 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 11 must be completed by each corporate officer or each partner.

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| Identification of applicant |
| Refer to instruction number 2, for information on the requirements for being a Permit holder. |
| **10.1 Personal Details** |
| Title: |     | Forename/s: |       | Surname: |       | Date of birth: |       |  |
| Address: |       | Suburb: |       | Postcode: |      |  |
| Postal address:  |       | Suburb: |       | Postcode: |      |  |
| Mobile number: |       | Email:  |       |  |
| Position in business: |       |  |
| **10.2 Certified true 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). |
| **10.3 Role in relation to Permit**  |
|  | [ ]  | The individual 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 12,13,14 and 15 in Part 2 and **attach** a CV1  |
|  | [ ]  | A partner: only applicable if the Permit will be issued to a partnership |
|  |  | Complete Sections 12,13,14 and 15 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.* |

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| Qualifications of applicant applying as an individual person |
| Complete this section if you are a medical practitioner or nurse 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. |
| An individual applicant can be a medical practitioner, nurse practitioner or registered nurse – tick which one applies:  |
| **[ ]** Medical practitioner | **[ ]** Nurse practitioner | **[ ]** Registered nurse |  |
| AHPRA registration number: |        | Registration expiry date: |        |  |
| **11.1 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. |
| **11.2 Access to imprest medicines and authority within the business** |
|  | **[ ]**   | Please check to confirm you will always have access to the imprest medicines stored at the facility. |
|  | **[ ]**  | Please check to confirm you will have authority within the residential care facility to determine policies and procedures in relation to managing the imprest medicines listed on the Permit. |
| 1 |

**Part 2: Personal Information: Applicant**

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| Prior licences/permits for medicines /poisons held by applicant |
| To be completed by the nominated individual Permit holder, each corporate officer or each partner. |
| **12.1** | 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: |
|  |       |  |
|  |       |  |
|  |
| **12.2** | 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: |
|  |       |  |
|  |       |  |
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| Criminal **check** for applicant |
| **13.1** | **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
 |
| **13.2** | **Indictable offences1**  |
|  | Role in relation to the Permit: |
|  | * 1. [ ]  individual medical practitioner, nurse practitioner or registered nurse
 |
|  |  | 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.
 |
|  | 1Minor traffic offences are not classified as indictable offences  |

**Part 2: Personal Information: Applicant**

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| Financial resources of applicant  |
| To be completed by the nominated individual Permit holder, each corporate officer or each partner. |
| **14.1** | Have you been declared bankrupt or a debtor under any bankruptcy law?  |
|  | [ ]  No |
|  | [ ]  Yes: What date was/will your bankruptcy be discharged? |       |  |
| **14.1** | 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 |
|  |

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| Declaration by applicant |
| This declaration must be signed by the applicant: individual medical practitioner, nurse practitioner or registered nurse, each corporate officer or each partner) and includes probity check consent.Please refer to Instruction 7 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 Residential Care 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 imprest 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 residential care facility, 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 person responsible for imprest medicines at the facility and assesses identification, fitness and probity.

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| Identification of responsible person |
| The role of the responsible person is to manage the imprest 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 the medicines at the facility. |
| **16.1** Will the individual applicant applying to be Permit holder, also be responsible for the facility 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. |
| **16.2 Personal Details of responsible person** |
|  | Title: |     | Forename/s: |       | Surname: |       | Date of birth: |       |  |
|  | Postal Address: |       | Suburb: |        | Postcode: |      |  |
|  | Mobile number: |       | Email: |       |  |
|  | Position in business: |       |  |
| **16.3 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). |
|  |

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| **Quali**fications of responsible person |
| **17.1 Qualifications of responsible person** |
|  | **[ ]** Medical practitioner | **[ ]** Nurse practitioner | **[ ]**  Registered nurse | **[ ]** Enrolled nurse |
| **17.2 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**

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| Prior licences/permits for medicines/poisons held by responsible person |
| **18.1** | 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: |
|  |       |  |
|  |       |  |
|  |       |  |
|  |
| **18.2** | 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: |
|  |       |  |
|  |       |  |
|  |       |  |
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| Criminal check for responsible person |
| **19.1** | **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
 |
| **19.2** | **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
 |
|  | 1Minor traffic offences are not classified as indictable offences  |
|  |

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

|  |
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| Declaration by nominated responsible person  |
| This declaration must be signed by the nominated responsible person and includes probity check consent. Please refer to Instruction 7 for information on acceptable signatures. |
| 1. I acknowledge my role is to manage the imprest 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 Residential Care 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: |       |  |
|  |

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# PART 4: PAYMENT and CHECKLIST

|  |
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| Payment |
| **Fee: $380** |
| Comprising a non-refundable application fee of $218 and 1 year Permit fee of $162.Permit fee will only 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:  **$380** |
|  | 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: **$380** |
|  | 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

Please email completed form and other requested documentation to: 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 Residential Care 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 3.2) |
| [ ]  | If storing Schedule 8 imprest medicines, photos of safe etc as required in Section 6.3 |
| [ ]  | If storing S8 imprest 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 6.3.3.a) |
| [ ]  | Copy of relevant sections if there are multiple facilities (Section 8) |
| [ ]  | Declaration signed and dated by **applicant (**nominated Permit holder)and witnessed (Section 9) |
| **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 10.2). 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 10.3) |
| [ ]  | If the applicant is an individual person, attach a copy of the medical practitioner, nurse practitioner or registered nurse currentannual registration certificate or wallet card provided by AHPRA. **Do not** provide an extract of the information available on AHPRA’s public website. (Section 11.1) |
| [ ]  | 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 13.1) |
| [ ]  | If the applicant is an individual medical practitioner, nurse practitioner or registered nurse 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 13.2. 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 13.2.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 13.2.b ii) |
| [ ]  | Declaration about personal information of applicant signed by applicant (Section 15) |
| **Part 3: Personal information, fitness and probity for responsible person** |
| [ ]  | Copy of photographic identification which must be certified as a true copy. (Section 16.3) 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 17.2) |
| [ ]  | 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 19.1) |
| [ ]  | 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 19.2) |
| [ ]  | Declaration about personal information of responsible person signed and dated (Section 20) |
| **Part 4: Declaration and Payment** |
| [ ]  | Payment details completed with correct signature **if** paying by credit card (Section 21)  |

# 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 thickAll 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 thickMust be fitted flush to the cabinet/body with a maximum clearance of 1.5 mm when closedHinge 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 diameterIf 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 thickAll 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 thickMust be fitted flush to the cabinet/body with a maximum clearance of 1.5 mm when closedHinge system must be a system that does not allow the door to be opened if the hinge is removedMust 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 |  |