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| 1. **Prescriber details**
 |
| First name: |       | Surname: |       |
| Prescriber number: |       | AHPRA registration number: |       |
| Practice name: |       |
| Address: |       | Suburb: |       | Postcode: |       |
| Telephone: |       | Fax:  |       | Practice email:  |       |
| Do you have any restrictions placed on your Schedule 8 prescribing by any authority? |
| [ ]  Yes, please provide details:  |      ­­­ | [ ]  No |
| Approved Prescriber eligibility category, please attach documentation: |
| [ ]   | Medical practitioner approved by the TGA as an “Authorised Prescriber” |
| [ ]   | Medical practitioner prescribing for patients enrolled in a clinical trial approved by a Human Research Ethics Committee |
| [ ]   | Relevant specialist medical practitioner (please specify in Section 2) |
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| 1. **Specialist category**
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| [ ]  | Neurologist  | [ ]  | Rehabilitation Physician |
| [ ]  | Other, please specify:  |       |
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| 1. **Applicant declaration**
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| I understand and will comply with the requirements for Cannabis-Based Product prescribing in Western Australia as set out in the *Medicines and Poisons Regulations 2016* and *Schedule 8 Medicines Prescribing Code* including: * submitting a *Notification of Treatment: Cannabis-Based Products* form when initiating treatment with Cannabis-Based Products, when patient or co-prescriber details change, or when treatment is ceased;
* obtaining prior written individual patient authorisation from the Chief Executive Officer of the Department of Health where required by the *Schedule 8 Medicines Prescribing Code;*
* participating in audits concerning the prescribing of Cannabis-Based Products if required by the Department of Health; and
* advising the Medicines and Poisons Regulation Branch if any details on this form change.
 |
| Signature: |       | Date: |       |
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| **Office Use Only**  |
| Approval number: |  |  |
| Processed by: |  | Date: |  |  |
| Checked by: |  | Date: |  |  |
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