# Victorian Pharmacy Authority

*Level 2, 15-31 Pelham St*
*Carlton Vic 3053*
**Tel: 03 9653 1700 Fax: 03 9653 1750 Email: applications@pharmacy.vic.gov.au**


## Form VP17

# APPLICATION FOR A LICENCE TO CARRY ON A PHARMACY DEPARTMENT

**[SECTION 36 *PHARMACY REGULATION ACT 2010*]**

To be completed when the applicant is a registered funded agency, registered community health centre, private hospital, or privately-operated hospital within the meaning of the *Health Services Act 1988* that is acting in accordance with the provisions of the *Health Services Act 1988.*

**To be completed by the Chief Executive Officer or Director of Pharmacy**

**1.1 Name and office address of applicant:**
*(Name and address of registered funded agency, registered community health centre, private hospital, or privately-operated hospital)*
Name:

Address:

**P/Code**

**Type of entity:**

- ☐ Registered Fund Agency
- ☐ Registered Community Health Centre
- ☐ Private Hospital
- ☐ Privately Operated Hospital

**1.2 Name and address of the premises at which the pharmacy department is to be established or carried on:**
Name:

Address:

**P/Code**

**Important note:**
The applicant must not establish or carry on a pharmacy department until the Authority has approved the premises of the pharmacy department. If the Authority has not approved the premises you may apply for approval by submitting an '**Application for approval of pharmacy department premises'.** The application form may be obtained from the Authority's offices or website [*www.pharmacy.vic.gov.au*.].

**1.3 Write the reason for your application:**

Eg: You require approval to -

- establish a new pharmacy department, or
- carry on an a pharmacy department that you currently operate in new (relocated) premises, or
- carry on an existing pharmacy department that you do **not** currently operate (eg you intend to purchase or take control of a registered funded agency, private hospital, or privately-operated hospital with an existing pharmacy department.

**1.4 If *relocating* a pharmacy department from existing premises, state the address of the *existing* premises at which the department is carried on.**

**P/Code**

**1.5 Name of Pharmacist in Charge of the Pharmacy Department**

Name Registration No.

**1.6 DECLARATION & UNDERTAKING**

I,

(*Insert name and position)*

declare that the information provided in this application is true and correct, that I am familiar with the *Pharmacy Regulation Act 2010* and I will take all reasonable steps to maintain the premises and conduct the pharmacy department in accordance with that Act.

**Please sign below:** **Please PRINT your name and your position below:**

**Dated: / /**

**WITNESS: Please sign below:** **Please PRINT your name legibly**

**Dated: / /**

**1.7 Contact details** *(where you would like all correspondence in relation to this application to be sent)*

**Name:**

**Address:**

**P/Code:**

**Phone/Mobile:** **Fax:**

**Email:**

**1.8 STATUTORY FEE**
**A statutory application fee is required with this application.**

## APPLICATION FEE PAYMENT DETAILS

☐ CHEQUE or MONEY ORDER payable to **Victorian Pharmacy Authority**

☐ CREDIT CARD (CC) – VISA OR MASTERCARD ONLY – COMPLETE DETAILS:

**VISA or MASTERCARD** (Please circle)

Credit Card Number:

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

**EXPIRY DATE** ☐☐ / ☐☐

**CVV** ☐☐☐

**AMOUNT $340.00**** (This fee is exempt from GST (Division 81))
** Amount valid for period **1 May 2019 to 30 April 2020**

**Name on Credit Card:**

…..…….. ……..
SIGNATURE OF CREDIT CARD HOLDER

Personal information on these forms is collected for the primary purpose of administering the Pharmacy Regulation Act 2010. Personal information will not be disclosed to any other person or agency unless you have given us permission, or we are required or authorised by law. For further information on collection and disclosure of personal information by the Authority, or how to request access or correction to your personal information, please refer to the Authority's Privacy Collection Notice and Privacy Policy.