



## Victorian Pharmacy Authority

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Carlton Vic 3053

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### Form VP41

**APPLICATION FOR APPROVAL TO SUPPLY, COMPOUND OR DISPENSE IN  
SPECIAL CIRCUMSTANCES PURSUANT TO SECTION 29(1)(b)  
OF THE *PHARMACY REGULATION ACT 2010***

**Section 29(1)(b) of the *Pharmacy Regulation Act 2010* states:**

A registered pharmacist must not supply, compound or dispense medicines except:

- a) from a pharmacy or pharmacy department that is approved by the Authority; or
- b) in any other special circumstances that are approved by the Authority in a particular case.

#### APPLICANT

**Name, registered address and registration number of the pharmacist who is the applicant:**

Name: \_\_\_\_\_ Registration No: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

P/Code: \_\_\_\_\_

\_\_\_\_\_

#### 1. GENERAL

- 1.1 State the name and exact location of the place, which is NOT a pharmacy or a pharmacy department, where you propose to supply, compound or dispense in special circumstances:**

\_\_\_\_\_

- 1.2 State who will have access to the drug storage area (e.g. pharmacists, doctors, nurses):**

\_\_\_\_\_

**1.3 What type of organisation is this place?** (e.g. Nursing Home, Private Hospital, Medical Centre)

.....

**1.4 Will the activities be linked to or associated with a pharmacy or pharmacy department?** YES / NO

If **YES** state name and address of the pharmacy or pharmacy department and provide a brief description of the association.

.....

		<b>Postcode:</b>
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>

.....

.....

**1.5 If you answered NO to Q 1.4, provide details of the pharmacist who will regularly and usually be in charge of the service:**

Title:                      Name:

.....

AHPRA Registration Number:

**2 SERVICE**

**2.1 State the type of service you intend to provide (What are you going to be doing? Specify if you will be handling cytotoxic or other hazardous substances or compounding medicines including any complex or sterile compounding.)**

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.....

**2.2 State the type of client that will use your service (e.g. inpatients, outpatients, residents).**

.....

.....

**2.3 State why you cannot or you do not wish to provide this service from a pharmacy or pharmacy department.**

.....

.....

**2.4** State how you will make records of supply, compounding or dispensing, including what information you will record and what steps you will take to ensure the confidentiality and integrity of these records (e.g. pass-word protected dispensing computer with regular back-ups).

.....

.....

**2.5** State how and where you will provide counselling to your clients and what steps you will take to ensure that this counselling is done in private.

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.....

**2.6** List the mandatory texts that you will have directly available to you while providing this service. (A list of texts is available on the Pharmacy Board Australia website: <http://www.pharmacyboard.gov.au/Codes-and-Guidelines.aspx>)

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**2.7** List other items of equipment that will be available to you e.g. scales and weights, dispensing measures, C&A Labels, telephone.


**3 PLANS**

**3.1 Enclose a sketch floor plan of the work area, drawn to scale, clearly showing: -**  
*(if an item is not applicable in your circumstances write **N/A** adjacent to the relevant item on this form)*

- i) perimeter of the work area showing the location of doors and windows; including:
  - location, and dimension of all dispensing benches;
  - location of stainless steel sink with hot and cold water taps;
  - location of drugs of addiction safe,
  - location of drug refrigerator;
  - location of computer equipment;
  - location of shelving for the storage of stock medicines;
  - location of the area for the storage of dispensed medicines awaiting collection or delivery;

- ii) location of the area or areas for the storage for sale of any over-the-counter medicines including S3 poisons that should not be:-
  - readily accessible to the public;
  - stored in a way which will promote their sale;
  - stored in a way or in quantity that will draw undue attention to them

*(these areas may be in the dispensary).*
- iii) location and dimensions of all areas to be used for prescription reception and counselling showing any screens or other arrangements for privacy;
- (iv) location of the area that will be used for POS data entry and other general clerical tasks  

*(this area must not be in the dispensing area);*
- (v) location and dimensions of professional trading area  
*(i.e. the area set aside for the placement and selling of therapeutic and prophylactic medicines, first-aid and sickroom supplies, surgical stock, animal health supplies and health information cards and books);*
- (vi) location and dimensions of all storerooms and unpacking areas;
- (vii) location and dimensions of the general trading area;
- (viii) location and dimensions of all other rooms or areas, e.g. sterile/cytotoxic preparation rooms, office, staffroom, beauty treatment room, ear piercing room, pregnancy testing room, toilets.

**3.2 Enclose a location plan, showing the area surrounding the premises, including buildings, roadways, footpaths, walkways and car parks.**

**4 SECURITY**

**4.1 Perimeter - Describe how the perimeter of the building is protected from illegal entry.**

**i) Doors:**

.....

**ii) Windows:**

.....

**iii) Skylights:**

.....

.....

**4.2 Alarm System**

(a) What sensors are provided

**Movement detector**

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

**Door / Window Switches**

<input type="checkbox"/>	<input type="checkbox"/>
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Other (state type):- .....

(b) Will an alarm system, fitted with a siren and monitored to a central monitoring station on a 24-hour basis, be installed?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

**5 STATUTORY FEE**

A fee is required to accompany this application. (See payment details below).

**6 DECLARATION**

I / We hereby declare that the information provided in this application for Approval to supply, compound or dispense medicines in special circumstances is true and correct -

**Name and registration number of pharmacist seeking approval:**

**Signature and date**


**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:**

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## APPLICATION FEE PAYMENT

A statutory fee of **\$145.00** is required to be paid.

Please go to the Victorian Pharmacy Authority website [www.pharmacy.vic.gov.au](http://www.pharmacy.vic.gov.au) to pay the application fee under “**Forms/payments**”.

Email the completed form & payment receipt together to [applications@pharmacy.vic.gov.au](mailto:applications@pharmacy.vic.gov.au)

**Note: This application will not be processed unless the correct application payment receipt is attached.**

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.