

Application to carry on business as a pharmacist by a beneficiary of a deceased approved pharmacist

Description of phormacy promises

Purpose of this form

Complete this form to apply to the Australian Government Department of Health and Aged Care (department) for approval, under section 90 of the *National Health Act 1953* (Act), of a beneficiary of a deceased approved pharmacist to carry on business at the premises described in question 2 of this form.

For more information

 $\label{thm:constraint} \mbox{Go to } \mbox{www.health.gov.au/pbsapproved suppliers}.$

For assistance completing this form, email

pbsapprovedsuppliers@health.gov.au and a departmental officer will contact you, or call 1800 316 389 (call charges may apply).

Returning your form

Check that all required questions are answered and the form is signed and dated.

This form, and any related attachments, must be lodged via the PBS Approved Suppliers Portal (Portal)

PBSApproved Suppliers. health. gov. au.

Further information on how to lodge your form is available at **www.health.gov.au/pbsapprovedsuppliers** under Guides and Forms – How to upload PDF forms or additional requested information.

Please do **not** email your form as emailed forms may not be processed. Please do **not** email your form in addition to uploading it via the Portal as this adds to the processing time for all submissions.

Privacy and your personal information

Personal information is protected by law, including the *Privacy Act 1988.*

Personal information is being collected in this form by the department for the purposes of assessing your application for approval, as a beneficiary (or beneficiaries) of a deceased approved pharmacist at specified premises, to supply pharmaceutical benefits at those premises under section 90 of the Act.

If you do not provide this information, the department will not be able to assess your application.

You can get more information about the way in which the department will manage personal information, including our privacy policy, at www.health.gov.au/pbsapprovedsuppliers/forms-privacy.

| Description of pharmacy premises | | | | | |
|----------------------------------|--|--|--|--|--|
| 1 | Current approval number | | | | |
| 2 | Pharmacy business (trading) name | | | | |
| | Building name | | | | |
| | Unit Suite Shop Floor number | | | | |
| | Street number | | | | |
| | Street name | | | | |
| | Suburb | | | | |
| | State Postcode | | | | |
| 3 | Postal address (if different to above) Postcode | | | | |
| | | | | | |
| | | | | | |
| 4 | Business phone number Email | | | | |
| | | | | | |

| Be | neficiary/beneficiaries | Pe | ermission holder (executor) |
|----|--|----|---|
| 5 | I/we am/are the beneficiary/beneficiaries named in the Will of | 7 | I, (permission holder [executor]) |
| 6 | and request approval under section 90 of the Act to supply pharmaceutical benefits at the premises described in Description of pharmacy premises of this form with effect from / / Give details of all beneficiaries Beneficiary 1 | | request that my permission under section 91 of the Act, to carr on the business to supply pharmaceutical benefits at the premises described in <i>Description of pharmacy premises</i> of this form, be revoked. I request that this revocation take effect immediately prior to the granting of approval to the beneficiary named in <i>Beneficiary/beneficiaries</i> of this form. |
| | Family name | | Permission holder's signature |
| | First given name | | € D Date |
| | Second given name | | / / |
| | Is this beneficiary a registered pharmacist? | De | eclaration |
| | Yes State or territory of registration Registration number PHA Signature Date // Beneficiary 2 Family name First given name Second given name | 8 | I declare that: I am authorised to sign this declaration on behalf of all other applicants. I the information I have provided in this form is complete an correct. I understand that: I giving false or misleading information is a serious offence. Full name Signature Date |
| | Is this beneficiary a registered pharmacist? No Yes State or territory of registration Registration number PHA Signature | | |
| | Date / / | | |
| | If there are more than 2 beneficiaries, attach a separate sheet with details. | | |