Immunisation Service Permit Application Form

*Medicines and Poisons Act 2014*

Table of Contents

[INSTRUCTIONS and INFORMATION i](#_Toc97200456)

[PART 1: APPLICATION for an IMMMUNISATION SERVICE PERMIT 1](#_Toc97200457)

[1. Details of applicant (nominated Permit holder) 1](#_Toc97200458)

[2. Permits issued to a corporation or partnership 2](#_Toc97200459)

[3. Premises and building security details 2](#_Toc97200460)

[4. Vaccines required, storage and access 3](#_Toc97200461)

[5. Authorising administration of vaccines and consultations 4](#_Toc97200462)

[6. Qualifications of staff administering vaccines at relocated or new added premises 4](#_Toc97200463)

[7. Standard Operating Procedures 5](#_Toc97200464)

[8. Multiple premises 6](#_Toc97200465)

[9. Declaration by applicant to obtain a Permit 6](#_Toc97200466)

[PART 2: PERSONAL INFORMATION: APPLICANT 7](#_Toc97200467)

[10. Identification of applicant 7](#_Toc97200468)

[11. Qualifications of applicant applying as an individual person 7](#_Toc97200469)

[12. Prior licences/permits for medicines/poisons held by applicant 8](#_Toc97200470)

[13. Criminal check for applicant 8](#_Toc97200471)

[14. Financial resources of applicant 8](#_Toc97200472)

[15. Declaration by applicant 9](#_Toc97200473)

[PART 3: PERSONAL INFORMATION: RESPONSIBLE PERSON 10](#_Toc97200474)

[16. Identification of responsible person 10](#_Toc97200475)

[17. Qualifications of person responsible for a premises 10](#_Toc97200476)

[18. Prior licences/permits for medicines/poisons held by responsible person 11](#_Toc97200477)

[19. Criminal check for responsible person 11](#_Toc97200478)

[20. Declaration by nominated responsible person 11](#_Toc97200479)

[PART 4: PAYMENT and CHECKLIST 12](#_Toc97200480)

[21. Payment 12](#_Toc97200481)

[22. Checklist 13](#_Toc97200482)

[PART 5: APPENDIX 14](#_Toc97200483)

[Appendix A: Certifying true copies of photographic identification 14](#_Toc97200484)

|  |  |
| --- | --- |
| INSTRUCTIONS and INFORMATION | |
|  | This application form is for a new **Immunisation Service Permit** to obtain vaccines to provide an immunisation service. Immunisations may be administered at specific sites listed on the Permit or may be a mobile type service, where vaccination is undertaken at locations such as workplaces. If the service will be more comprehensive than vaccination alone, applicants should complete a Medical Treatment Permit Application.  If applying on behalf of a Residential Care Facility, the Residential Care Health Service Permit automatically covers influenza vaccinations for residents and 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 understand 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 an Immunisation Service 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 an Immunisation Service.  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: Appendix |
|  | **Permit holder and qualifications**  **2.1** **Permits can be issued to:**   1. Individual applicants (**medical practitioner** or **nurse practitioner only)**,who:  * must complete Part 2: Personal Information: Identification, Fitness and Probity and sign the declaration at Section 15. * must be registered with the Australian Health Practitioner Regulation Agency (AHPRA) * must have authority within the business to determine policies and procedures in relation to handling vaccines and adrenaline on the Permit and   + should consider their personal scope of practice and suitability when applying for this type of Permit.  1. Body corporate (corporation) or partnership where:    * 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.   **2.2 Permits issued to a corporation or partnership**  The corporation or partnership must always employ a Medical Director i.e. medical practitionerregistered with AHPRA, who must have authority within the business to determine policies and procedures in relation to managing vaccines within an immunisation service.  **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 premises 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. |

|  |  |  |
| --- | --- | --- |
|  | **Preferred Permit holder, administration of vaccines, SASAs**  If the Permit is to be held by an individual, it is preferable that the Permit holder is a medical practitioner as this ensures the Permit holder is the same person who will be authorising the Structured Administration and Supply Arrangement (SASA)1 documents. [Information about SASAs](http://ww2.health.wa.gov.au/Articles/S_T/Structured-Administration-and-Supply-Arrangements) is available on the Department of Health website. It is recommended that applicants read this information before submitting their application.  The following types of health practitioners can authorise **administration** of Schedule 4 vaccines:   1. Medical practitioner who can:    * give a direct order to a health practitioner2 or health professional3 to administer vaccines to each individual patient or    * authorise a Structured Administration and Supply Arrangements (SASA) on behalf of the immunisation service where vaccine administration can be initiated by the type of health practitioner2 or health professional3 named in the SASA without a prescription or direction by a medical practitioner for each individual patient.      + The SASA must be signed by the most senior medical practitioner employed in the immunisation service and      + Must be approved by a clinical governance committee which must include at least 3 members including a medical practitioner, a registered nurse and a pharmacist.      + ***Only a medical practitioner can authorise a SASA.***   Copies of SASAs issued under Health Service Permits must be sent to the Department of Health, however they do not have to accompany this Application Form and the Permit may be issued prior to the receipt of SASAs.   1. Nurse practitioner4 who can give a direct order to a health practitioner2 or health professional3 to administer vaccines to each individual patient. Nurse practitioners cannot sign off on a SASA.   If a nurse practitioner is the Permit holder, a medical practitioner (Medical Director) must be employed by the immunisation service if SASAs will be issued.  1 information about SASAscan be found at: [Information about SASAs](http://ww2.health.wa.gov.au/Articles/S_T/Structured-Administration-and-Supply-Arrangements)  2 the type of health *practitioner* who can administer vaccines is a person who is registered with AHPRA and also has authorisation under the Medicines and Poisons Regulations 2016 to administer Schedule 4 medicines, e.g. registered nurse, enrolled nurse, registered paramedic.  3 the type of health *professional* who can administer vaccines is a person who has authorisation under the Medicines and Poisons Regulations 2016 to administer Schedule 4 medicines. A health professional is not registered with AHPRA. e.g. medic.  4 a nurse practitioner applying to be a Permit holder must **attach** evidence showing their advanced nursing practice experience is applicable to an immunisation service. | |
|  | **Person responsible for a premises and qualifications**  An individual person must also be nominated to have overall responsibility for each premises included on the Permit. The role of the responsible person is to manage the vaccines on a day to day basis and be the contact person if the Permit holder is not available.  The responsible person for a premises must:   * be employed or contracted by the Permit holder (or be the Permit holder, see 4.1) * reside in WA * complete Part 3: Personal Information: Identification, Fitness, Probity, sign declaration at Section 20.   **4.1** **Responsible person for a Permit issued to an individual person:**  The responsible person for a premises 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 person (medical practitioner or nurse practitioner) and not a corporation or partnership **or** 2. the most senior medical practitioner, nurse practitioner or registered nurse at the premises   **4.2 Responsible person for a Permit issued to a corporation or partnership**  The responsible person for a premises 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 premises, **or** 2. the Medical 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 vaccines at every premises for which they are responsible. Where a single person is responsible for multiple premises, the Department may request further information in relation to this capacity. |
|  | **Standard Operating Procedures (SOP).**  This application requires the applicant to confirm the immunisation service has a number of SOP.  The Department may request that the SOP be made available for auditing purposes.  The issuing of a Permit does not imply approval or otherwise of the SOP. | |
|  | **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 A. | |
|  | **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. | |
|  | **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 premises inspection, * Please submit this application as a Word document or PDF and not a 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](mailto: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** | | |

|  |
| --- |
| PART 1: APPLICATION for an IMMMUNISATION SERVICE PERMIT |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 or nurse practitioner (tick which one applies) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | Medical practitioner | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | Nurse practitioner:must **attach** advanced nursing practice experience applicable to an immunisation service. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 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: | |  | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Part 1: Application for an Immunisation Service Permit**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Permits issued to a corporation or partnership | | | | | | | | | | |
| Is the applicant a corporation or partnership? | | | | | | | | | | |
|  | No, the applicant is an individual medical practitioner or nurse practitioner | | | | | | | | | |
|  | Yes: complete Section 2.1 and 2.2 | | | | | | | | | |
| **2.1** | **Check** to confirm the corporation or partnership always employs a registered Medical Director i.e. a medical practitioner who has authority within the business to determine policies and procedures in relation to managing vaccines and issue Structured Administration and Supply Arrangements (SASAs). | | | | | | | | | |
| **2.2** | **Details of medical director (medical practitioner)** | | | | | | | | | |
|  | Dr. | Forename(s): |  | | Surname: |  | | | |  |
|  | AHPRA registration number: | | |  | | | Expiry date: |  |  | |
|  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Premises and building security details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Section 3 must be completed for every premises listed on the Permit. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is this premises being acquired from another immunisation service provider? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes: | | | | | Name of previous immunisation service provider: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | |
|  | | | | The Department requires the previous Permit holder at the relocated or new added premises to remove the premises from their Permit. The application to remove the premises from the previous Permit holder’s Permit must be received by the Department prior to adding the relocated or new added premises to your Permit. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3.1 Premises details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Premises name (if applicable): | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | |
|  | | | Premises address: | | | | | | | | |  | | | | | | | | | Suburb: | | |  | | | | | | | Postcode: |  | | |  | |
|  | | | Telephone: | | | | | |  | | | | | | | | Fax: | | |  | | | | | | | Email: | |  | | | | | |  | |
|  | | | Date of possession of the premises (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 a premises** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Refer to instruction number 4, for information on the requirements for being responsible for a premises | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Details of nominated responsible person for the premises named in Section 3.1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Health practitioner type: | | | | | | | | | | Medical practitioner | | | | | | | | | Nurse practitioner | | | | | | | Registered nurse | | | | | | | |
|  | | | Title: | | | |  | | | Forename(s): | | | | | |  | | | | | | | | | | Surname: | |  | | | | | | |  | |
|  | | | The nominated responsible person **must complete Part 3**: Personal Information: Identification, Fitness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3.3 Location of premises** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Commercial | | | | | | | | | Industrial | | | | | | | Other-please specify: | | | | | | |  | | | | | | | | |  | | |
|  | | 3.3.1 | | | | Is local government approval required to operate an immunisation service from the premises? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | |  | | Yes: **attach** evidence of local government approval to operate an immunisation service from premises. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | |  | | No: Local government may be asked to comment on applications which may increase processing time | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3.4 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: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Part 1: Application for an Immunisation Service Permit**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Vaccines required, storage and access | | | | | | | |
| Section 4 must be completed for every premises listed on the Permit. | | | | | | | |
| Please check which vaccines will be required: | | | | | | | |
| Influenza vaccine | | | | | | | |
| SARS-COV-2 (COVID-19) vaccine | | | | | | | |
| All vaccines on WA Immunisation Schedule | | | | | | | |
| Please list other vaccines and any local anaesthetics and rescue medicines, such as adrenaline, that will be required. | | | | | | | |
| |  |  | | --- | --- | | **Name of vaccine** | **Approximate quantity required** | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | | | | | | | | |
| Note: all permits for immunisation services will also be issued as including adrenaline injection in Schedule 3. | | | | | | | |
| **4.1 Storage and temperature monitoring of Schedule 3 adrenaline and Schedule 4 vaccines** | | | | | | | |
|  | | 4.1.1 | | | Please **attach** a diagram of the premises, showing where the vaccines and adrenaline will be stored. | | |
|  | | 4..1.2 | | | Storage of adrenaline in Schedule 3 (Please check which one applies) | | |
|  | |  | | | Locked room  Locked cupboard | | |
|  | |  | | | Please **attach** photos of locked room or locked cupboard | | |
|  | | 4.1.3 | | | Storage of refrigerated vaccines (Please check which one applies) | | |
|  | |  | | | Locked room with a purpose-built vaccine refrigerator | Locked purpose-built vaccine refrigerator | |
|  | |  | | | Please **attach** photos of locked room with vaccine refrigerator in situ or locked vaccine refrigerator | | |
|  | | 4.1.4 | | | Please confirm vaccines will be stored in a purpose built vaccine refrigerator with a built in temperature monitoring data logger as per Section 3.1 of the [National Vaccine Storage Guidelines Strive for 5.](https://www.health.gov.au/sites/default/files/documents/2020/04/national-vaccine-storage-guidelines-strive-for-5.pdf) | | |
| **4.2 Storage area for scheduled medicines** | | | | | | | |
|  | | Please provide information for all areas storing scheduled medicines at the premises: | | | | | |
| |  |  | | --- | --- | | Floor number, room number/room name | Floor number, room number/room name | |  |  | |  |  | |  |  | | | | | | | | |
| **4.3 Access to scheduled medicines** | | | | | | | |
|  |  | | | Please check to confirm that only AHPRA registered health practitioners or health professionals authorised under the *Medicines and Poisons Act 2014* to possess scheduled medicines and employed by the immunisation service will have unsupervised access to the medicines and keys/entry codes to storage rooms and refrigerators. | | | |
| **4.4 Preventing access to scheduled medicines** | | | | | | | |
|  | | | Please describe how non-authorised staff such as reception staff, cleaners and members of the public (including family members and children) will be prevented from having access to scheduled medicines: | | | | |
|  | | |  | | | |  |
| **4.5 Loss or theft of Schedule 4 vaccines** | | | | | | | |
|  |  | | | Please check to confirm any loss or theft of Schedule 4 vaccines 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) | | | |

**Part 1: Application for an Immunisation Service Permit**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Authorising administration of vaccines and consultations | | | | | | | | | | | | | | | | | | | | | |
| Refer to instructions number 2 and 3. | | | | | | | | | | | | | | | | | | | | | |
| If Structured Administration and Supply Arrangements (SASAs) are used to authorise administration of vaccines, a medical practitioner must be employed or contracted by the immunisation service to sign off on the SASA, unless the Permit holder will be a medical practitioner. | | | | | | | | | | | | | | | | | | | | | |
| **5.1** **How will the administration of vaccines be authorised.**  **Check only one option** | | | | | | | | | | | | | | | | | | | | | |
|  | a. | |  | A face to face consultation between a medical practitioner or nurse practitioner and each patient occurs every time and administration of a vaccine is authorised at this time **or** | | | | | | | | | | | | | | | | | |
|  | b. | |  | A telemedicine consultation between a medical practitioner or nurse practitioner and each patient occurs every time and administration of a vaccine is authorised at this time **or** | | | | | | | | | | | | | | | | | |
|  | c. | |  | A combination of a and b – consultation method may be either face to face or via telemedicine but there is always a consultation between a prescriber and the patient and administration of a vaccine is authorised at this time **or** | | | | | | | | | | | | | | | | | |
|  | d. | |  | Each patient completes a medical history and consent form and a medical practitioner or nurse practitioner reviews the form before authorisation is given to administer the vaccine for each patient | | | | | | | | | | | | | | | | | |
|  | e. | |  | SASAs signed by the most senior medical practitioner employed or contracted by the immunisation service authorises health professionals without prescribing rights to initiate administration of a vaccine. A consultation between every patient and a prescriber does not occur prior to vaccination. *Complete Sections 5.2 and 5.3* **or** | | | | | | | | | | | | | | | | | |
|  | f. | |  | Other method (please describe): | | | | | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | |  | | |
| **5.2 Details of medical practitioner authorising SASAs** | | | | | | | | | | | | | | | | | | | | | |
|  | Name of authorising medical practitioner: | | | | | | | | | | |  | | | | | | | | |  |
|  | Usual practice address: | | | | | |  | | | | | | Suburb: | |  | | Postcode: |  |  | | |
|  | Telephone: | | | | |  | | | | Fax: |  | | | Email: | |  | | |  | | |
|  | AHPRA registration number: | | | | | | |  | | | | | | | | | | |  | | |
| **5.3 SASAs and Clinical Governance Committee** | | | | | | | | | | | | | | | | | | | | | |
|  | | Name of *medical practitioner:* | | | | | | |  | | | | | | | | | | |  | | |
|  | | AHPRA registration number: | | | | | | |  | | | | | | | | | | |  | | |
|  | | Name of *registered nurse:* | | | | | | |  | | | | | | | | | | |  | | |
|  | | AHPRA registration number: | | | | | | |  | | | | | | | | | | |  | | |
|  | | Name of *pharmacist:* | | | | | | |  | | | | | | | | | | |  | | |
|  | | AHPRA registration number: | | | | | | |  | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Qualifications of staff administering vaccines | | | | | | | | | |
|  | Which type of person will be administrating of vaccines? | | | | | | | | |
|  | * 1. Health practitioner registered with AHPRA: tick which health practitioner/s will be administering vaccines: | | | | | | | | |
|  | | | | medical practitioner nurse practitioner registered nurse enrolled nurse | | | | | |
|  | | | | registered paramedic  Aboriginal and Torres Strait Islander health practitioner | | | | | |
|  | | | | Other registered health practitioner, please describe**:** | | | | | |
|  | | | | | |  | | |  |
|  | | * 1. Health professional not registered with AHPRA but described in the Medicines and Poisons Regulations 2016 | | | | | | | |
|  | | | | medic | | | Aboriginal and Torres Strait Islander health worker | | |
|  | | | | Other health professional, please describe: | | | |  | |
|  | | | c. Will all staff administering vaccines have completed accredited or RTO delivered immunisation training? | | | | | | |
|  | | | | | Yes No | | | | |

**Part 1: Application for an Immunisation Service Permit**

|  |  |
| --- | --- |
| Standard Operating Procedures | |
| Check to **confirm** the immunisation service has the following Standard Operating Procedures (SOPs): | |
|  | **SOP** used for **ordering** vaccines and adrenaline from wholesalers or pharmaceutical companies which must support the following requirements: |
|  | 1. Orders must be approved by the Permit holder, registered health practitioner or health professional 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 vaccines being ordered for the business. |
|  | 1. Only registered health practitioners or health professionals authorised to adminsister vaccines should receive vaccines and adrenaline when delivered by wholesalers/manufacturer. Other staff such as reception staff cannot be designated as responsible for this task. |
|  | 1. Vaccines and adrenaline must be ordered from a licensed pharmaceutical wholesaler or manufacturer. |
|  | 1. Orders will be sent directly to the premises by the wholesaler or an alternative arrangement is described. |
|  | |
|  | **SOP** for **recording the administration** of vaccines to patients which must support the following requirements: |
|  | 1. Record of administration is made for each individual patient in the Patient Record. Minimum details include vaccine name, strength, dose administered and batch number. |
|  | 1. Records include name of registered health practitioner or health professional administering doses and person making the entry. |
|  | 1. Date of administration. |
|  | 1. Name and signature of person administering vaccine or, if records are kept electronically, the system will identify the person administering the vaccine through their logon ID. |
|  | 1. Details of any adverse events. |
|  | 1. All records for the administration of medicines in Schedule 4 are kept for a minimum of 2 years. |
|  | 1. Details of each instance of patient immunisation is entered into the Australian Immunisation Register (AIR). |
|  | |
|  | **SOP** which shows that all **adverse events** following immunisation (AEFI) will be reported according to [Adverse event following immunisation (AEFI) (health.wa.gov.au)](https://ww2.health.wa.gov.au/Articles/A_E/Adverse-event-following-immunisation-AEFI) and supports AEFI being reported by using [WA Vaccine Safety Surveillance (WAVSS) system](https://www.safevac.org.au/Home/Info/WA). |
|  | |
|  | **SOP** for **storage** and **transport** of vaccines which supports compliance with the [National Vaccine Storage Guidelines Strive for 5.](https://www.health.gov.au/sites/default/files/documents/2020/04/national-vaccine-storage-guidelines-strive-for-5.pdf) The SOPsupports the following requirements: |
|  | 1. Vaccines are stored in a purpose-built vaccine fridge that is only accessible to authorised registered health practitioners or health professionals. |
|  | 1. Vaccines are consistently stored and transported at 2-8 °C. |
|  | 1. In addition to weekly downloads of data logger information, twice daily temperature checks are recorded. |
|  | 1. Storage temperatures during transport are continuously monitored for temperature excursions. |
|  | 1. Ice packs or gel pack are conditioned, and the cooler is packed appropriately. |
|  | 1. Temperature monitoring of the vaccines occur in the cooler and action is taken for cold change breaches. |
|  | 1. Unused stock is returned to vaccine fridge. |
|  | |

**Part 1: Application for an Immunisation Service Permit**

|  |  |
| --- | --- |
| Multiple premises | |
| Will vaccines and adrenaline be stored at multiple premises under this Permit? | |
| No | |
| Yes: complete Sections 8.1 and 8.2 | |
| 8.1 Will the responsible person for the other premises be the same as the individual Permit holder or a person responsible for the premises named in Section 3.1? | |
|  | Yes |
|  | No: Complete and **attach** Part 3: Personal Information: Identification, Fitness for the nominated responsible person for the other premises. |
| 8.2 Will responses to Sections 5,6 and 7 be the same for the other premises as for the premises named in Section 3.1 | |
|  | Yes: Complete and **attach** Sections 3 and 4 for all other premises. |
|  | No: Complete and **attach** Sections 3,4,5,6 and 7 for all other premises. |
|  | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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) | | | | | |

|  |
| --- |
| PART 2: PERSONAL INFORMATION: APPLICANT |

**Part 2** assesses identification, fitness and probity of the Permit holder. If the Permit holder is an individual person,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.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 A 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.* | | | | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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. | | | | | | | | |
| **11.1** The individual applicant must be a medical practitioner or nurse practitioner– tick which one applies: | | | | | | | | |
|  | |  | | Medical practitioner | | | | |
|  | |  | | Nurse practitioner: must **attach** evidence showing their advanced nursing practice experience is applicable to an immunisation service. | | | | |
| AHPRA registration number: | | | | |  | Registration expiry date: |  |  |
| **11.2 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 the public AHPRA Register of Practitioners. | | | | | | | | |
| **11.3 Access to vaccines and adrenaline and authority within the business** | | | | | | | | |
|  |  | | Please check to confirm you will always have access to the vaccines stored at the premises listed on the Permit. | | | | | |
|  |  | | Please check to confirm that, you will have authority within the immunisation service to determine policies and procedures in relation to managing the vaccines and adrenaline listed on the Permit. | | | | | |
|  | | | | | | | | |

**Part 2: Personal Information: Applicant**

|  |  |  |
| --- | --- | --- |
| 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 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 Permit or Licence 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 Permit or Licence you applied for, why your application was refused and which state or territory the refusal occurred in: | |
|  |  |  |
|  |  |  |
|  | | |

|  |
| --- |
| Criminal check for applicant |
| To be completed by the nominated individual Permit holder, each corporate officer or each partner. |
| 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. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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? |  | |  | |
| **14.2** | 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 |
|  | | | | | |

**Part 2: Personal Information: Applicant**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Declaration by applicant | | | | | | | |
| This declaration must be signed by the applicant: individual medical practitioner or nurse practitioner, 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 an Immunisation Service 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 vaccines and adrenaline 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 Immunisation service, a corporate officer (if the applicant is a corporation) or a partner (if the applicant is a partnership) | | | | | | |
| Signature: | |  | Name: |  | Date: |  |  |
|  | | | | | | | |

|  |
| --- |
| PART 3: PERSONAL INFORMATION: RESPONSIBLE PERSON |

**Part 3** must be completed by the responsible person and assesses identification, fitness and probity.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Identification of responsible person | | | | | | | | | | | | | | | | | | | | | | | | |
| The role of the responsible person is to manage the vaccines and adrenaline 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 a premises. | | | | | | | | | | | | | | | | | | | | | | | | |
| **16.1** Will the individual applicant applying to be Permit holder, also be responsible for the premises 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 A for a list of persons authorised to certify a true copy). | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Quali**fications of person responsible for a premises | | | | | | | |
| **17.1 Qualifications of responsible person** | | | | | | | |
|  | Medical practitioner | Nurse practitioner | | Most senior registered nurse at the premises | | | |
| **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 the public AHPRA Register of Practitioners. | | | | | | | |

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

|  |  |  |
| --- | --- | --- |
| 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 Permit or Licence 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: | |
|  |  |  |
|  |  |  |
|  |  |  |
|  | | |

|  |
| --- |
| Criminal check for responsible person |
| 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. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 vaccines and adrenaline 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 an Immunisation Service 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: |  |  |
|  | | | | | | |

# 

# PART 4: PAYMENT and CHECKLIST

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Payment | | | | | | | | | | | | | | | | | | |
| **Fee: $370** | | | | | | | | | | | | | | | | | | |
| Comprising a non-refundable application fee of $212 and 1 year Permit fee of $158.  Permit fee only will 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:  **$370** | | | | | | | | | | | |
|  | 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: **$370** | | | | | |
|  | 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](mailto:mprb@health.wa.gov.au)

Please email completed form and other requested documentation to: [mprb@health.wa.gov.au](mailto: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 an Immunisation Service Permit** | |
|  | If the applicant is a nurse practitioner, attach evidence showing advanced nursing practice experience is applicable to an immunisation service (Section 1.1) |
|  | 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 applicable, evidence of local government approval to operate the business from the premises (Section 3.3.1) |
|  | Diagram of the premises, showing where the vaccines and adrenaline will be stored (Section 4.1.1) |
|  | Photo of locked room or locked cupboard for storing adrenaline (Section 4.1.2) |
|  | Photo of locked purpose-built vaccine refrigerator or locked room showing refrigerator in situ (Section 4.1.3) |
|  | Copy of relevant sections if there are multiple premises (Section 8) |
|  | Declaration signed, by **applicant** (individual Permit holder, corporate officer or partner) (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 A 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 individual applicant is a nurse practitioner, attach evidence showing advanced nursing practice experience is applicable to an immunisation service (Section 11.1). Also requested in Part 1, Section 2. |
|  | Copy of medical practitioner or nurse practitioner’s current registration certificate/ wallet card provided by AHPRA.  Note: please do not provide an extract of the information available on the public AHPRA Register of Practitioners. (Section 11.2) |
|  | If applicable, a Statutory Declaration relating to an offence under the *Medicines and Poisons Act 2014* or a repealed corresponding law or corresponding law in another state or territory (Section 13) |
|  | Declaration about personal information signed by applicant (individual Permit holder, corporate officer or partner) (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 A for a list of persons authorised to certify a true copy. |
|  | Copy of the responsible person’s currentannual registration certificate or wallet card provided by AHPRA.  Note: please **do not** provide an extract of the information available on the public AHPRA Register of Practitioners. (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 corresponding law in another state or territory (Section19) |
|  | Declaration about personal information signed by responsible person (Section 20) |
| **Part 4: Declaration and Payment** | |
|  | Payment details completed with correct signature if paying by credit card (Section 21) |

# PART 5: APPENDIX

## Appendix A: 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 |  |