Australian Government

Department of Health and Aged Care

Authority to permit person(s) to enquire and/or sign claim forms on behalf of approved pharmacist(s)

Purpose of this form

Complete this form if you are an owner of a pharmacy approved under section 90 of the *National Health Act 1953* (Act).

Use this form to:

- provide details to the Australian Government Department of Health and Aged Care (department) of all persons working at the approved pharmacy who are permitted to:
  - enquire on behalf of the approved pharmacist(s), and/or
  - sign pharmaceutical benefit claim forms and endorse pharmaceutical benefit prescriptions on behalf of the approved pharmacist(s); and
- remove from the approved pharmacy record any person previously permitted who is not named in this form.

Important information

This new authority will invalidate any previous authority you may have submitted, and anyone not named at question 3 of this form as a permitted person will be removed from your approved pharmacy record. Therefore, it is important you include details of all current permitted persons, even if you have provided these details before.

Any requests or changes relating to the approved pharmacy record will continue to be accepted from the business owner(s) only.

For more information

Go to **www.health.gov.au/pbsapprovedsuppliers**.
For assistance completing this form, email details of your enquiry to **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) **PBSApprovedSuppliers.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 processing your authority to permit person(s) to enquire and/or sign pharmaceutical benefit claim forms and endorse pharmaceutical benefit prescriptions on your behalf.

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

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.**

Business owner(s)

1 Details must be provided for all business owners (i.e. pharmacists and/or company directors and/or friendly society approved representatives).

Business owner 1

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Business owner 2

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Business owner 3

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Business owner 4

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

If there are more than 4 business owners attach a separate sheet with details.

Approved premises

2 Provide details of the approved pharmacy premises

PBS approval number

Pharmacy business (trading) name

Address of approved pharmacy premises

Postcode

Pharmacy phone number

Email

Permitted person(s)

3 Provide details of all person(s) working at the approved pharmacy who are permitted to enquire and/or sign pharmaceutical benefit claim forms and endorse pharmaceutical benefit prescriptions on behalf of the approved pharmacist(s).

Permitted person 1

Select whichever applies

Pharmacy staff ☐ (permitted to enquire only)

Pharmacist ☐

Registration number

P H A

Dr ☐ Mr ☐ Ms ☐ Other

Family name of permitted person

First given name of permitted person

Signature of permitted person

Permitted person 2

Select whichever applies

Pharmacy staff ☐ (permitted to enquire only)

Pharmacist ☐

Registration number

P H A

Dr ☐ Mr ☐ Ms ☐ Other

Family name of permitted person

First given name of permitted person

Signature of permitted person

Permitted person 3

Select whichever applies

Pharmacy staff ☐ (permitted to enquire only)

Pharmacist ☐

Registration number

P H A

Dr ☐ Mr ☐ Ms ☐ Other

Family name of permitted person

First given name of permitted person

Signature of permitted person

Permitted person 4

Select whichever applies

Pharmacy staff ☐ (permitted to enquire only)

Pharmacist ☐

Registration number

P H A

Dr ☐ Mr ☐ Ms ☐ Other

Family name of permitted person

First given name of permitted person

Signature of permitted person

If there are more than 4 permitted persons attach a separate sheet with details.

Contact person's details

4 Provide details of the person the department should contact about this form if required.

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Organisation

Position

Daytime phone number

Email

Declaration

This declaration must be signed by one of the business owners named at question 1 of this form.

5 On behalf of the business owner(s) named at question 1 of this form:

I declare that:

- the information provided in this form is complete and correct.
- the dispensing of drugs and medicinal preparations will be performed under the direct supervision of a pharmacist at the premises specified at question 2 of this form, in accordance with Part VII of the Act and the regulation made under the Act.

I authorise:

- the person(s) whose signature(s) appear at question 3 of this form to:
  - enquire on my/our behalf, and/or
  - sign pharmaceutical benefit claim forms and endorse pharmaceutical benefit prescriptions on my/our behalf*.
- removal from my/our approved pharmacy record of any person previously permitted who is not named at question 3 of this form.

I understand that:

- only pharmacists are permitted to sign pharmaceutical benefit claim forms and endorse pharmaceutical benefit prescriptions.
- only those person(s) named at question 3 of this form will be included in my/our approved pharmacy record as permitted to act as authorised above.
- this authority does not remove the approved business owner(s) named at question 1 of this form from my/our approved pharmacy record.
- giving false or misleading information is a serious offence.

Name

Signature

Date / /

Clear form Print form