Australian Government

Department of Health

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

Purpose of this form

Complete this form to apply for approval, under Section 90 of the *National Health Act 1953*, 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

Go to **www.health.gov.au/pbsapprovedsuppliers**.
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.

Applications must be lodged through the PBS Approved Suppliers Portal **PBSApprovedSuppliers.health.gov.au**.

For further information on how to lodge your application visit **www.health.gov.au/pbsapprovedsuppliers**. Please do **not** email your application as emailed applications may not be processed.

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 Australian Government Department of Health (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 National *Health Act 1953*.

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

Beneficiary/beneficiaries

5 I/we am/are the beneficiary/beneficiaries named in the Will of

and request approval under section 90 of the *National Health Act 1953* to supply pharmaceutical benefits at the premises described in *Description of pharmacy premises* of this form with effect from

/ /

6 Give details of all beneficiaries

Beneficiary 1

Family name

First given name

Second given name

Is this beneficiary a registered pharmacist?

No

Yes ▶ State or territory of registration

Registration number

PHA

Signature

Date

/ /

Beneficiary 2

Family name

First given name

Second given name

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.

Permission holder (executor)

7 I, (permission holder [executor])

request that my permission under section 91 of the *National Health Act 1953*, to carry on the business to supply pharmaceutical benefits at the premises described in *Description of pharmacy premises* of this form, be revoked.

I request that this revocation take effect immediately prior to the granting of approval to the beneficiary named in *Beneficiary/beneficiaries* of this form.

Permission holder's signature

Date

/ /

Declaration

8 **I declare that**:

- I am authorised to sign this declaration on behalf of all other applicants.
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Full name

Signature

Date

/ /