



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 the approved pharmacist(s) and business owner(s) of a pharmacy approved under section 90 of the *National Health Act 1953*.

Use this form to:

- provide details of any person(s) working at the approved pharmacy who is 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 approved pharmacists (business owners) 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 by all approved pharmacists (the business owners).

This authority form must be lodged through the PBS Approved Suppliers Portal PBSApprovedSuppliers.health.gov.au or by email to pbsapprovedsuppliers@health.gov.au.

For further information on how to lodge your form via the PBS Approved Suppliers Portal, refer to Frequently Asked Questions at www.health.gov.au/pbsapprovedsuppliers.

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 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.

Approved pharmacist(s) (the business owners)

- 1 Details must be provided for all approved pharmacists, being the pharmacy business owners and/or company directors and/or friendly society approved representatives.

Approved pharmacist 1

Dr Mr Ms Other

Family name

First given name

Approved pharmacist 2

Dr Mr Ms Other

Family name

First given name

Approved pharmacist 3

Dr Mr Ms Other

Family name

First given name

Approved pharmacist 4

Dr Mr Ms Other

Family name

First given name



If there are more than 4 approved pharmacists attach a separate sheet with details.

Contact person's details

- 4 Provide details of the person the Department of Health should contact about this form if required.

Dr Mr Ms Other

Family name

First given name

Organisation

Position

Daytime phone number

Email

Declaration

- 5 This declaration must be signed by all approved pharmacist(s) named at question 1 of this form.

I/we 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 *National Health Act 1953* and the regulation made under the *National Health Act 1953*.

I/we 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/we 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 pharmacist(s) named at question 1 of this form from my/our approved pharmacy record.
- giving false or misleading information is a serious offence.

Signature of approved pharmacist 1

	Date
	/ /

Signature of approved pharmacist 2

	Date
	/ /

Signature of approved pharmacist 3

	Date
	/ /

Signature of approved pharmacist 4

	Date
	/ /



If there are more than 4 approved pharmacists attach a separate sheet with details.