

You cannot modify this template.

Legal and professional obligations declaration by a proprietor or manager

I, *(name)*

being the proprietor/manager of *(pharmacy name)*

located at *(pharmacy address)*

of PBS Approval Number

and QCPP ID Number

declare that:

I have confirmed all pharmacists employed or contracted to work in my pharmacy have current registration with the Pharmacy Board of Australia.

I have confirmed all pharmacists employed or contracted to work in my pharmacy have undertaken a self assessment against the PSA Professional Practice Standards within the past 12 months and I am satisfied with the results of the self assessments.

I have confirmed all pharmacists employed or contracted to work in my pharmacy have current individual professional indemnity insurance.

I have confirmed this pharmacy complies with all legislative requirements relating to the operation of the pharmacy.

I have confirmed this pharmacy has no contracts (excluding tenancy leases) that restrict our ability to stock products or provide services that meet the therapeutic needs of our consumers.

I declare that staff members of this pharmacy are aware of the Australian Charter of Health Care Rights.

I declare that all *Pharmacy Medicines* and *Pharmacist Only Medicines* are stored in the Professional Services Area.

I declare that all staff members who supply or handle *Pharmacy Medicines* or assist the pharmacist with the supply of *Pharmacist Only Medicines* meet the requirements of a recognised course as per template checklist T2C.

I declare that the information provided on this declaration is true and accurate.

I declare that I have the authority to make this declaration on behalf of this pharmacy.

Signed:

Date:

Pharmacy proprietor/manager

Print name:

Notes: The T1A Legal and Professional Obligations Declaration must be declared:

- Within one month of your assessment for accreditation and
- 12 months from your accreditation (as advised by the QCPP Division).

Please send to the QCPP by mail:

Administration, QCPP
PO Box 7036
Canberra Business Centre, ACT, 2610.

or fax to: 02 6270 1885

Please complete the page overleaf.

Services provided in the pharmacy (tick/specify)

<input type="checkbox"/> Dose Administration Aids	<input type="checkbox"/> Staged Supply	<input type="checkbox"/> Clinical Interventions
Disease State Management:		Screening and Risk Assessment:
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Health Promotion
<input type="checkbox"/> Respiratory Conditions	<input type="checkbox"/> Respiratory Conditions	
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Cardiovascular Disease	
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Mental Health	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Needle and Syringe Program	<input type="checkbox"/> Opioid Substitution Program	<input type="checkbox"/> Interprofessional Collaboration
<input type="checkbox"/> Return of Unwanted Medicines	<input type="checkbox"/> Medicine Adherence	<input type="checkbox"/> Preparation of Cytotoxic Drug Products
<input type="checkbox"/> Smoking Cessation Service	<input type="checkbox"/> Drug Information Service	<input type="checkbox"/> Patient Medication Profile
<input type="checkbox"/> Services to Residential Care Facilities	<input type="checkbox"/> Complex Compounding	<input type="checkbox"/> Medication Management Review

Other services (tick/specify)

<input type="checkbox"/> Deliveries	<input type="checkbox"/> Hire of equipment	<input type="checkbox"/> Access Point for the National Diabetes Subsidy Scheme
<input type="checkbox"/> Distance supply	<input type="checkbox"/> Internet pharmacy	<input type="checkbox"/> E-Health

Statistical data

Please provide the following information about your pharmacy, effective as at the date of this return. **Note:** Reasons for 'not applicable' must be documented.

Pharmacy Name: _____

How many pharmacists are employed in the pharmacy?
(including casual and part-time pharmacists expressed as full time equivalent positions (FTE))

How many non-pharmacist staff members are employed in the pharmacy?
(including casual and part-time staff expressed as full time equivalent positions (FTE))

What are your standard opening hours, Monday to Friday?

What are your standard opening hours, Saturday?

What are your standard opening hours, Sunday?

Which days of the year do you not trade?

Are there any languages other than English spoken by any of your staff members and can they assist your customers?
(List the languages)

Pharmacy size: (approximate square metre area)

Is this pharmacy a member of a pharmacy group (consisting of 5 or more pharmacies)? Yes/No

If Yes, please state group name(s)

Tick this box if you do not give The Pharmacy Guild of Australia permission to use the above data as per Rule 34 of the Program and Assessment Rules

**Complete this form to declare your pharmacy is eligible to receive
payment under the Pharmacy Practice Incentives Program**

I, _____
(print name)

Being the proprietor/pharmacist manager of

(Eligible Community Pharmacy Name)

of PBS Approval Number _____

and QCPP ID Number _____

declare that:

1. This Eligible Community Pharmacy has been assessed by an approved Pharmacy Accreditation Program for the ____ / ____ financial year, as eligible for an annual payment under the following PPI priority areas (tick all that apply):
 Staged Supply Community Service Support
 Primary Health Care Working with Others
2. I acknowledge that payments for the above priority areas will be made prospectively in accordance with the PPI Program Specific Guidelines.
3. By signing this declaration, I further declare: I have read and agree to the current 5CPA General Terms and Conditions and the PPI Program Specific Guidelines for these PPI priority areas.
4. This Eligible Community Pharmacy agrees to meet the 5CPA General Terms and Conditions and PPI Program Specific Guidelines and is eligible for payment against the PPI priority areas indicated above.
5. This Eligible Community Pharmacy displays and complies with the Community Pharmacy Service Charter.
6. The information provided in this form is true and correct.
7. I have the authority to make this declaration on behalf of this Eligible Community Pharmacy, and understand this may lead to the recovery of any payments made to this Eligible Community Pharmacy by the Australian Government (as represented by the Department of Human Services and the Department of Health and Ageing).
8. I agree to provide evidence of my authority to make this declaration if requested by the Australian Government.

Authorised Pharmacist's Full Name:

Authorised Pharmacist's Signature:



Date: ____ / ____ / ____

**Full name of person (Witness) before whom the
declaration is made (in printed letters)**

Signature of Witness:



Date: ____ / ____ / ____

Privacy note: The information contained within this declaration may be disclosed at any time to, the Australian Government (as represented by the Department of Human Services and Department of Health and Ageing), the Pharmacy Guild of Australia or as authorised or required by law.

Please send to the QCPP Division by mail:

Administration, QCPP Division
PO Box 7036
Canberra Business Centre, ACT, 2610

or by fax to: 02 6270 1885

Office Use Only:

PPI selections correct: Date: ____ / ____ / ____

PPI selections updated: Date: ____ / ____ / ____

Notes: