

**QCPP PROFESSIONAL SERVICE**

**EXPANSION FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| Pharmacy Name | Click here to enter text. | QCPP ID | Click here to enter text. |
| Pharmacy Contact Person | Click here to enter text. | PBS Number | Click here to enter text. |
| Phone Number | Click here to enter text. | Email Address | Click here to enter text. |

# EXPANSION APPLICATION INSTRUCTIONS

|  |  |
| --- | --- |
|  | This form aims to assist pharmacies maintain compliance with QCPP rules 31 and 32 that relate to the implementation and/or advertising of additional professional services commenced between assessments within the two-year accreditation cycle. 1. Complete this cover sheet indicating the services applied for, the declaration and acknowledge the payment details.
2. Fill-out a service information form for each service applied for
3. Submit the completed forms by fax (02 6270 1885) or email (help@qcpp.com)
 |

## Expansion Service Selection

Please tick the new services being applied for:

|  |  |  |  |
| --- | --- | --- | --- |
| tick | Element 2 - Supply of medicines medical devices and poisons | tick | Element 3 - Delivery of health programs and services |
|[ ]  Clinical Interventions *P2H, T2G*  |[ ]  Opioid Substitution Program *T3A* |
|[ ]  Interprofessional Collaboration *P2I, T2E*  |[ ]  Dose Administration Aids *T3B* |
|[ ]  Staged Supply *P2K, T2F*  |[ ]  Screening and Risk Assessment *T3C* |
|[ ]  Distance Supply *T2A* |[ ]  Needle and Syringe Program *T3D* |
|  |  |[ ]  Smoking Cessation Service *T3E* |
|[ ]  Other Service (Please specify below): |[ ]  Medication Management Review *T3F* |
|  | Click here to enter text. |[ ]  Services to Residential Care Facilities *T3G* |
| \* If your pharmacy is looking to provide a service relating to Hiring Equipment, please contact QCPP directly on 1300 363 340 to advise of the service and it will be determined if and when additional assessments will be undertaken.  |[ ]  Health Promotion *T3H* |
|  |[ ]  Disease State Management Service *T3I* |
|  |[ ]  Medicine Adherence *T3J* |
|  |[ ]  In-pharmacy Medicine Review *T3K* |
|  |[ ]  Absence from Work Certificates *T3L* |
|  |[ ]  Vaccination Services in the Pharmacy *T3M* |

## Declaration

I Click here to enter text. (full name) declare that:

* the above information is true and accurate;
* I have authority to make this declaration on behalf of the pharmacy;
* I understand that successful application will only provide provisional service accreditation; and,
* I will be assessed against the QCPP requirements for these professional services during my next external assessment.

Signed: Click here to enter text. Date: Click here to enter a date.

## Payment Details

## Charges for applications are $100 (plus GST) for each professional service. You will be sent an invoice via the email you have provided on this form. Please note that prompt payment is advised as applications will not be progressed until the account is paid in full.

## Service Information Section *(Please complete one form for each expansion service)*

|  |  |  |  |
| --- | --- | --- | --- |
| Pharmacy Name | Click here to enter text. | QCPP ID | Click here to enter text. |
| Expansion Service  | Click here to enter text. | Date Service Commenced | Click here to enter text. |

|  |  |
| --- | --- |
|  | Please refer to the QCPP Requirements Manual for specific professional service requirements. Relevant QCPP policy, procedures and template documents are noted in italics in the Service Selection section of the cover sheet for your reference. Additional pages or evidence may be attached if the space below is insufficient. |

|  |  |  |
| --- | --- | --- |
| **Program requirement** | **Questions** | **Provide an explanation of the service to be provided** |
| 1. Resources
 | How will the pharmacy ensure the pharmacy is able to deliver this services as well as its day-to-day operations? Adequate staff | Click here to enter text. |
| 1. Training and qualifications
 | What relevant qualifications or relevant training have the person(s) delivering the service obtained?  | Click here to enter text. |
| 1. Reference material
 | What current reference materials are available?  | Click here to enter text. |
| 1. Equipment to support the program
 | What equipment is available to support the service? What Personal Protective Equipment (PPE) and hand hygiene facilities are relevant and available? If applicable, how are clinical waste and/or sharps disposed of?  | Click here to enter text. |
| 1. Equipment calibration and maintenance
 | What calibration and maintenance does the pharmacy perform on the equipment to ensure the equipment is appropriately maintained and serviced? How does the pharmacy ensure that this is recorded? (eg. in the pharmacy’s T5B Equipment Calibration/ Maintenance Schedule and Record?) | Click here to enter text. |
| 1. Facilities to support the program
 | Where is this service delivered? *Describe the service/consultation area in the pharmacy and attach a photo.* | Click here to enter text. |
| 1. Procedures required
 | What procedures are in place for this service? *Please attach a copy of the procedure* | Click here to enter text. |
| 1. Recording system
 | How will records, which align with the requirements of the relevant QCPP checklists, be maintained for this service? Describe the information collected, method of collection (electronic/paper patient record) as well as how these records are stored. *Please attach a template or a screenshot of a blank or de-identified record.* | Click here to enter text. |

## Service Information Section *(Please complete one form for each expansion service)*

|  |  |  |  |
| --- | --- | --- | --- |
| Pharmacy Name | Click here to enter text. | QCPP ID | Click here to enter text. |
| Expansion Service  | Click here to enter text. | Date Service Commenced | Click here to enter text. |

|  |  |
| --- | --- |
|  | Please refer to the QCPP Requirements Manual for specific professional service requirements. Relevant QCPP policy, procedures and template documents are noted in italics in the Service Selection section of the cover sheet for your reference. Additional pages or evidence may be attached if the space below is insufficient. |

|  |  |  |
| --- | --- | --- |
| **Program requirement** | **Questions** | **Provide an explanation of the service to be provided** |
| 1. Resources
 | How will the pharmacy ensure the pharmacy is able to deliver this services as well as its day-to-day operations? Adequate staff | Click here to enter text. |
| 1. Training and qualifications
 | What relevant qualifications or relevant training have the person(s) delivering the service obtained?  | Click here to enter text. |
| 1. Reference material
 | What current reference materials are available?  | Click here to enter text. |
| 1. Equipment to support the program
 | What equipment is available to support the service? What Personal Protective Equipment (PPE) and hand hygiene facilities are relevant and available? If applicable, how are clinical waste and/or sharps disposed of?  | Click here to enter text. |
| 1. Equipment calibration and maintenance
 | What calibration and maintenance does the pharmacy perform on the equipment to ensure the equipment is appropriately maintained and serviced? How does the pharmacy ensure that this is recorded? (eg. in the pharmacy’s T5B Equipment Calibration/ Maintenance Schedule and Record?) | Click here to enter text. |
| 1. Facilities to support the program
 | Where is this service delivered? *Describe the service/consultation area in the pharmacy and attach a photo.* | Click here to enter text. |
| 1. Procedures required
 | What procedures are in place for this service? *Please attach a copy of the procedure* | Click here to enter text. |
| 1. Recording system
 | How will records, which align with the requirements of the relevant QCPP checklists, be maintained for this service? Describe the information collected, method of collection (electronic/paper patient record) as well as how these records are stored. *Please attach a template or a screenshot of a blank or de-identified record.* | Click here to enter text. |

## Service Information Section *(Please complete one form for each expansion service)*

|  |  |  |  |
| --- | --- | --- | --- |
| Pharmacy Name | Click here to enter text. | QCPP ID | Click here to enter text. |
| Expansion Service  | Click here to enter text. | Date Service Commenced | Click here to enter text. |

|  |  |
| --- | --- |
|  | Please refer to the QCPP Requirements Manual for specific professional service requirements. Relevant QCPP policy, procedures and template documents are noted in italics in the Service Selection section of the cover sheet for your reference. Additional pages or evidence may be attached if the space below is insufficient. |

|  |  |  |
| --- | --- | --- |
| **Program requirement** | **Questions** | **Provide an explanation of the service to be provided** |
| 1. Resources
 | How will the pharmacy ensure the pharmacy is able to deliver this services as well as its day-to-day operations? Adequate staff | Click here to enter text. |
| 1. Training and qualifications
 | What relevant qualifications or relevant training have the person(s) delivering the service obtained?  | Click here to enter text. |
| 1. Reference material
 | What current reference materials are available?  | Click here to enter text. |
| 1. Equipment to support the program
 | What equipment is available to support the service? What Personal Protective Equipment (PPE) and hand hygiene facilities are relevant and available? If applicable, how are clinical waste and/or sharps disposed of?  | Click here to enter text. |
| 1. Equipment calibration and maintenance
 | What calibration and maintenance does the pharmacy perform on the equipment to ensure the equipment is appropriately maintained and serviced? How does the pharmacy ensure that this is recorded? (eg. in the pharmacy’s T5B Equipment Calibration/ Maintenance Schedule and Record?) | Click here to enter text. |
| 1. Facilities to support the program
 | Where is this service delivered? *Describe the service/consultation area in the pharmacy and attach a photo.* | Click here to enter text. |
| 1. Procedures required
 | What procedures are in place for this service? *Please attach a copy of the procedure* | Click here to enter text. |
| 1. Recording system
 | How will records, which align with the requirements of the relevant QCPP checklists, be maintained for this service? Describe the information collected, method of collection (electronic/paper patient record) as well as how these records are stored. *Please attach a template or a screenshot of a blank or de-identified record.* | Click here to enter text. |