

APPLICATION FOR SPECIAL PURPOSE REGISTRATION AS A PHARMACIST

Section 105, Pharmacists Registration Act 2001



Pharmacists Board of Queensland

**Please read the Accompanying Guidelines
before completing this form.**

**Complete Form and Return with Accompanying Documents
to address below.**



Mailing Address:

Pharmacists Board of Queensland
GPO Box 2438
BRISBANE QLD 4001



Enquiries:

Telephone: (07) 3225 2516
Facsimile: (07) 3225 2527
Monday to Friday 9.00 am – 4.00 pm
Email: pharmacy@healthregboards.qld.gov.au
Website www.pharmacyboard.qld.gov.au



Location:

8th Floor, Forestry House
160 Mary Street
BRISBANE QLD 4000

***YOUR APPLICATION WILL NOT BE
PROCESSED WITHOUT ALL THE
REQUIRED DOCUMENTATION,
THE APPLICATION FEE AND THE
REGISTRATION FEE.***

APPLICATION DETAILS - Please ✓ Appropriate Box and Print Complete Information as per Accompanying Information sheets. **ALL SECTIONS OF THIS FORM MUST BE COMPLETED.**

TITLE: (circle preferred title) **MR MRS MS MISS DR OTHER** _____

(please specify)

FAMILY NAME _____

GIVEN NAME/S (in full) _____

PREVIOUS NAME(S) (if applicable) _____

LANGUAGES SPOKEN (other than English) _____

Date of Birth _____	Place of Birth _____	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
	Country of Birth _____	

REGISTRATION/POSTAL ADDRESS (For inclusion in the public register) All Changes must be notified to the Board _____ _____ _____ Postcode _____ Is this your residential address? YES <input type="checkbox"/> NO <input type="checkbox"/> If "Yes" do you agree that it be available for inspection on the Register? YES <input type="checkbox"/> NO <input type="checkbox"/> If you do not tick any of these boxes, and the address above is not a P.O. Box, an address will NOT appear against your name in the register.	PROFESSIONAL / BUSINESS ADDRESS (if different from Registration address) _____ _____ _____ Postcode _____	RESIDENTIAL ADDRESS (if different from Registration address) _____ _____ _____ Postcode _____
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CONTACT TELEPHONE NUMBERS: Day _____ After Hours _____ Mobile _____

EMAIL ADDRESS: _____

QUALIFICATIONS ON WHICH APPLICATION IS BASED: (earliest qualification first)

Degree /Diploma /Examination and/or Assessment Certificate	University/College/Examining Body	Year Conferred
_____	_____	_____
_____	_____	_____

REGISTRATION: (if not previously registered, write NA)

1. State/Territory/Country where first registered as a **pharmacist** _____ and year _____

2. Do you hold registration that gives you legal authority to currently practise as a **pharmacist** elsewhere?
YES NO
If Yes, give the State/Territory/Country _____

3. Have you ever been registered as a **health practitioner*** in another State or Territory of Australia or another country ? YES NO
If yes, give State/Territory/Country and indicate profession _____

4. Have you ever been registered as a **health practitioner*** in Queensland?
*see definition on page 4 YES NO
If yes, give profession and year registered _____

SPECIAL PURPOSE REGISTRATION (please tick the category for which you are applying)

- study or train at postgraduate level
- teach
- engage in research
- give clinical demonstrations

Details of the special purpose activity

SUITABILITY TO BE A SPECIAL PURPOSE REGISTRANT:

If you answer "Yes" to any of the following, please provide full details on a separate sheet.

- | | | |
|--|--------------------------|--------------------------|
| 1. Have you been convicted of an indictable offence? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been convicted of an offence against the <i>Pharmacists Registration Act 2001</i> , the <i>Pharmacists Act 1976 (repealed)</i> , the <i>Health Practitioners (Professional Standards) Act 1999</i> , or a corresponding law? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been registered under the <i>Pharmacists Registration Act 2001</i> or the <i>Pharmacists Act 1976 (repealed)</i> , or are you or have you been registered under a corresponding law applying, or that applied, in another State, or territory, or country, and the registration was affected either by an an undertaking, the imposition of a condition, suspension or cancellation, or in any other way? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has your registration as a health practitioner ever been cancelled or is your registration currently suspended as a result of disciplinary action in any Australian State or Territory or in a foreign country? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been refused registration as a health practitioner in any Australian State or Territory, or in a foreign country? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |

Note:

- If you answered **Yes** to any of the above questions you must attach a full explanation of the circumstances and details of any condition or current disciplinary or other orders to which you are subject. (Please attach in a sealed envelope).
- The term '**health practitioner**' includes any registered provider of services directed at maintaining, improving or restoring people's health and wellbeing or any functionary aspect thereof.
- Please see attached information sheet for an explanation of criminal history.
- The Board may enquire with relevant authorities regarding an applicant's criminal history.

ADDITIONAL COMMENTS OR INFORMATION FROM APPLICANT IN SUPPORT OF REQUEST FOR SPECIAL PURPOSE REGISTRATION AS A PHARMACIST. (if insufficient space set out on separate page)

REFEREES: Give name, address, occupation and telephone number of two persons practising in your profession who have known you for at least the past twelve months.

Name _____ Name _____

Address _____ Address _____

Position _____ Position _____

Telephone _____ Postcode _____ Telephone _____ Postcode _____

I consent to the Pharmacists Board of Queensland making enquiries of, and exchanging information with, the authorities of any Australian States or Territories regarding my practice as a health practitioner or otherwise regarding matters relevant to this application.

I declare that the above statements are true and correct, that I am the person named in the attached documents and that I am the person in the attached photographs which bears my signature and are a recent likeness as certified on the back by

I also undertake to comply with all relevant legislation, codes of practice, and Pharmacists Board of Queensland policies.

.....
Printed Name of Applicant

.....
Signature of Applicant

.....
Printed Name of Witness

.....
Signature of Witness

Date: day of20.....

ITEMS TO BE ATTACHED WITH THIS APPLICATION

[All photocopies must be certified as true copies by a Justice of the Peace, a Commissioner for Declarations, or a Notary.]

1. **APPLICATION AND REGISTRATION FEES** **THIS IS A TAX INVOICE**
 - The fees due with this application are GST exempt and are set out in the accompanying Information Sheet.
 - Please note: Fees due with this application only cover registration until 30 June (the end of the registration year). [Renewal of registration beyond 30 June is subject to you applying between 1 May and 30 June each year for registration renewal and paying the associated annual registration fee.]
2. **PROOF OF IDENTITY:**
 - certified copy of driver's licence, passport, or other official identification document which includes a photograph
 - certified copy of marriage certificate or other document evidencing change of name (if applicable)
 - statutory declaration for any name changes
3. **TWO RECENT PASSPORT-TYPE PHOTOGRAPHS WITH SIGNATURE ON THE BACK AND CERTIFIED AS A TRUE LIKENESS**
4. **PROOF OF QUALIFICATIONS:**
 - certified copy of qualifications
 - **TRANSLATIONS** (where applicable) - English translation of any documents must be by a certified translator.
5. **PROOF OF REGISTRATION STATUS ELSEWHERE** (Only applicable if you hold legal authority to currently practise elsewhere.)
 - certified copy of current annual practising certificate from registration body elsewhere
6. **A letter from the relevant university, association or body detailing the special activity for which registration is being sought.**

ADDITIONAL DOCUMENTATION REQUIRED

If you are currently, or were recently, registered elsewhere, a Certificate of Good Standing must be provided directly to the Board from each registration body with whom you hold or recently held registration. It is your responsibility to arrange for the Certificate/s of Good Standing to be forwarded directly from the registration body to the Board. The date of issue of a Certificate of Good Standing must not pre-date your application by more than 3 months.

~~~~DO NOT DETACH~~~~

**Credit Card Payments** (Visa, Mastercard or Bankcard through mail or over counter only; not by fax or phone)

For this payment to be accepted you must complete all sections below.

To assist with credit card processing, please provide a daytime contact no:- \_\_\_\_\_

VISA

MASTERCARD

BANKCARD

CARD NUMBER \_\_\_\_\_

EXPIRY DATE

CARD HOLDER'S NAME

(print)

CARD HOLDER'S  
SIGNATURE

AMOUNT \$

## PRIVACY STATEMENT

The Pharmacists Board respects your privacy. The Pharmacists Board is collecting the information on this form in order to register you as a Pharmacist and carry out other functions relevant to the administration of the *Pharmacists Registration Act 2001*. (The fully shaded sections of the form may not be specifically or generally mandated by the Act, but have been included in order to be able to confirm your identity and to expedite the processing of your application).

Your name, registration address, qualifications, type of registration and any conditions of registration will be entered on the Register, which is available to the public for inspection (with the exception that your residential address will only be available if you have given notice to the Board that you agree to the details being able to be inspected).