

PHARMACY REGULATION AUTHORITY SA

ABN 96 624 565 034

General Manager

Peter Halstead BPharm, GAICD, AACP, MPS

4/12-20 Bagot Street

NORTH ADELAIDE SA 5006

Phone: (08) 8267 6218

Web: www.pharmacyauthority.sa.gov.au

FORM B

**INFORMATION TO BE PROVIDED
BY A
CORPORATE/TRUSTEE
PHARMACY SERVICES PROVIDER**

Health Practitioner Regulation National Law (South Australia) Act 2010

Section 51(1)(b) and (c) of the *Health Practitioner Regulation National Law (South Australia) Act 2010*, ('the Act'), provides that only pharmacist controlled companies/trusts that are recognised corporate/trustee pharmacy services providers may operate registered premises.

Under Section 26(3) of the Act, a recognised corporate pharmacy services provider is:

- ❖ a complying pharmacist controlled company
- ❖ a complying friendly society
- ❖ a company that carried on a pharmacy business on 1 August 1942 and has continued to do so since that date

Under Section 26(4) of the Act, a recognised trustee pharmacy services provider is any pharmacist controlled trust.

Note: Under Section 65 of the Act, a person must not make a statement that is false or misleading in a material particular (whether by reason of the inclusion or omission of any particular) in any information provided under Part 4 'Pharmacy Practice' of the Act.

Maximum penalty: \$20 000

Under section 27 of the Oaths Act 1936. it is an offence to make a false declaration and a person can be liable, upon conviction, to be imprisoned for up to four years.

Please include with this application, copies or the relevant company constitution and/or related trust deeds.

1. COMPANY/TRUST DETAILS	
1.1. Company/Trust Name	_____
1.2. Registration Number: (if applicable)	_____
1.3. Registered Office Address: (if applicable)	_____
	State: _____ Postcode: _____

1.4. **Company/Trust Postal Address:(if applicable)**

State: _____ Postcode: _____

1.5. **Telephone Number:**

_____ **Fax Number:** _____

1.6. **Email Address:**

2. PHARMACY PREMISES AT WHICH PHARMACY SERVICES ARE PROVIDED

2.1. Provide the names and addresses of the registered pharmacy premises at which the corporate pharmacy services provider operates :

Name of the Pharmacy:

Pharmacy Address:

State: _____ Postcode: _____

Name of the Pharmacy:

Pharmacy Address:

State: _____ Postcode: _____

2.1. Provide the names and addresses of the registered pharmacy premises at which the corporate pharmacy services provider operates :

Name of the Pharmacy:

Pharmacy Address:

_____ State: _____ Postcode: _____

Name of the Pharmacy:

Pharmacy Address:

_____ State: _____ Postcode: _____

Name of the Pharmacy:

Pharmacy Address:

_____ State: _____ Postcode: _____

Name of the Pharmacy:

Pharmacy Address:

_____ State: _____ Postcode: _____

PERSONS OCCUPYING POSITIONS OF AUTHORITY

Please provide the full names and addresses of all persons occupying a position of authority in the recognised corporate/trustee pharmacy services provider.

Section 26(5) of the Act provides that a person occupies a position of authority in a recognised corporate/trust pharmacy services provider if the person:

- (a) is a director of the body corporate; or
- (b) exercises, or is in a position to exercise, control or substantial influence over the body corporate in the conduct of its affairs; or
- (c) manages, or is to manage, the business of the body corporate insofar as that business
- (d) consists of the provision of pharmacy services; or.
- (e) where the body corporate is a proprietary company- is a shareholder in the body corporate;

Section 26(6) of the Act provides that a person who holds more than 10% of the issued share capital of a public company will be regarded as a person occupying a position of authority in that company.

Section 26(7) of the Act provides that a person occupies a position of authority in a recognised trustee pharmacy services provider if the person is a trustee or beneficiary of the trust.

Please attach additional forms (duplicates of section 3.1. overleaf) for each individual occupying a position of authority in the recognised corporate/trustee pharmacy services provider as required.

3.1 **Individuals Details** (Duplicate this page as needed)

Name (in full)
Residential Address)

State: _____ Postcode: _____

Postal Address

State: _____ Postcode: _____

Pharmacist registration
number (if applicable) or a
Prescribed relative of a
Director/Trustee who is
registered and particulars of
relationship

PHA : _____

Involvement of the individual in the company/trust:

- | | |
|--|----------|
| Is the individual a company directors / trustee of the company / trust | Yes / No |
| Does the individual have control or substantial influence over the company / trust | Yes / No |
| Is the individual responsibility for company / trust management | Yes / No |
| Is the individual a company shareholder / beneficial owner of the company / trust | Yes / No |

With regard to the registered pharmacy premises at which the corporate pharmacy services provider operates (Section 2.1):

Please indicate the total hours per month you are personally present within the registered pharmacy premises? _____ **hours**

In relation to the hours mentioned above what proportion (%) of the time is spent on:

- | | |
|---|---------|
| - Dispensing / Customer involvement : | _____ % |
| - Business activities (ie: Human resources, IT etc) | _____ % |

Please outline the documented practices/procedures in place to ensure appropriate oversight is applied to all activities occurring within the pharmacy premises?

4. COMPLIANCE

Tick the appropriate box to reflect the company's compliance as a recognised corporate/trustee pharmacy services provider under section 26 of the *Health Practitioner Regulation National Law (South Australia) Act 2010*.

4.1. **Pharmacist controlled company**

This means a company within the meaning of the *Corporations Act 2001 of the Commonwealth*

- (a) In which
- (i) at least one (1) director is a pharmacist, and
 - (ii) every director is either a pharmacist or a prescribed relative of a pharmacist
- and
- (b) Where each holder of shares, or of a beneficial or legal interest in shares, in the company is
- (i) a pharmacist or prescribed relative of a pharmacist, or
 - (ii) a recognised corporate pharmacy services provider, or
 - (iii) a recognised trustee pharmacy services provider
- and
- (c) In which a pharmacist is, or pharmacists are, entitled to control the exercise of at least 50% of the voting power
- (i) at meetings of directors of the company, or
 - (ii) attached to voting shares issued by the company.

4.2. **Friendly society**

This means a company that is a friendly society under the *Corporations Act 2001 of the Commonwealth* and that

- (a) provides mutual benefit to its members, and
- (b) is a non-profit organisation, and
- (c) has at least 100 members, and
- (d) has a constitution that provides that the main object of the company is to carry on the business of a pharmacy.

4.3. **Company pre 1st August 1942**

A company that carried on a pharmacy business on 1st August 1942 and has continued to do so since that date, other than

- (a) Friendly Society Medical Association Limited, or
- (b) The Mount Gambier United Friendly Societies Dispensary Limited

4.4. **Pharmacist controlled trust**

This means a trust where each trustee is

- (a) a pharmacist, or
- (b) a prescribed relative of a pharmacist as long as at least 1 other trustee is a pharmacist, or
- (c) a pharmacist controlled company, or
- (d) a person of a prescribed class

5. DECLARATION

I solemnly and sincerely declare that

- ❖ I am authorised by the company/trust to make this application on its behalf the statements made in this application are true and correct in every particular to the best of my knowledge and belief
- ❖ the company has and will maintain professional indemnity insurance cover of \$20 million or more against civil liabilities that might be incurred by the recognised corporate/trustee pharmacy services provider
- ❖

I have provided a copy of the company constitution and/or trust deeds and any other relevant documentation and information

and

I make this solemn declaration conscientiously believing the same to be true and by the virtue of the provisions of the Oaths Act 1936 and I understand that it is an offence to make a false declaration under the Oaths Act 1936 punishable by up to four years imprisonment and may also result in a breach of section 65 of the Act which carries a maximum penalty of \$20,000.

Signature

Name (PRINT clearly)

Date (dd/mm/yy)

Declare at _____

this the _____ day of _____ in the year _____

Witnessed before me _____ (see below)

Tick whichever is applicable

A Justice of the Peace

A Notary Public

A Commissioner for Taking Affidavits

A Proclaimed Member of the Police Force-

(includes solicitors on the role of

Practitioners of the Supreme Court)

** If attested by a Proclaimed Police Office, include the name of town or place where stationed.

7. PAYMENT

Amount Payable is \$525.00

This fee is exempt from GST (Division 81).

A receipt will be emailed to the company / trust email address.

Tick the appropriate payment type.

Cheque

EFTPOS (in person)

CASH (in person)

Mastercard/Visa

No other card types are accepted

Card Number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Card Expiry (MM/YY)

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
----------------------	----------------------	---	----------------------	----------------------

Name on the Card

Signature of Cardholder

Date

<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
----------------------	---	----------------------	---	----------------------