Australian Government

Department of Health

Authority to authorise pharmacist(s) to sign claim forms on behalf of section 91 permission holder

Purpose of this form

As permission holder under section 91 of the *National Health Act 1953*, you must complete this form to authorise a pharmacist(s) to sign pharmaceutical benefit claim forms and endorse pharmaceutical benefit prescriptions on your behalf.

For more information

Go to **www.health.gov.au/pbsapprovedsuppliers**.
For assistance completing this form, email **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.

This authority form must be lodged through the PBS Approved Suppliers Portal **PBSApprovedSuppliers.health.gov.au**.

For further information on how to lodge your form visit **www.health.gov.au/pbsapprovedsuppliers**. Please do **not** email your form as emailed forms may not be processed.

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 assessing your authorisation of a pharmacist(s) to 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**.

Permission holder

1 Name of permission holder

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Approved premises

2 PBS approval number

3 Address of pharmacy premises

Postcode

Authorised pharmacist(s)

4 Give details of all authorised pharmacists

Authorised pharmacist 1

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Registration number

P H A

Signature

Authorised pharmacist 2

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Registration number

P H A

Signature

Authorised pharmacist 3

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Registration number

P H A

Signature

Authorised pharmacist 4

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Registration number

P H A

Signature

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

Previously authorised pharmacist(s)

5 Please list here any previously authorised pharmacists you want to cancel

Authorised pharmacist name

Authorised pharmacist name

Authorised pharmacist name

Authorised pharmacist name

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

Declaration

6 **I declare that**:

- the information I have 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 3, in accordance with Part VII of the *National Health Act 1953* and the regulation made under the *National Health Act 1953*.

I understand that:

- giving false or misleading information is a serious offence.

I authorise the pharmacist(s) whose signature(s) appear in question 4, to:

- sign pharmaceutical benefit claim forms.
- endorse pharmaceutical benefit prescriptions on my behalf.

Permission holder's signature

Date

/ /

Clear form Print form