Australian Government
Department of Health

Notification of a prescribing-only hospital

Purpose of this form

As a state or territory participating in the Pharmaceutical Reforms, complete this form to notify the Australian Government Department of Health (the Department) of approval of a public hospital to prescribe pharmaceutical benefits in accordance with the applicable Pharmaceutical Reform Agreement.

For more information

Go to **www.health.gov.au/pbsapprovedsuppliers**.
For assistance completing this form email details of your enquiry to **pbsapprovedsuppliers@health.gov.au** and a departmental officer will contact you, or call **1800 316 389** (call charges may apply).

Returning your form

Check all required questions are answered and the form is signed and dated.

This notification 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 Department for the purposes of processing your notification of approval of a public hospital to prescribe pharmaceutical benefits in accordance with the relevant State or Territory Pharmaceutical Reform Agreement. The Department may use and if necessary disclose this personal information for the purpose of administering the Pharmaceutical Benefits Scheme.

If you do not provide this information, the Department will not be able to process your notification.

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**.

Hospital details

Details of the public hospital that is the subject of this notification

1 Hospital name

2 Hospital provider number

3 Hospital address

Postcode

4 Hospital switchboard phone number

Hospital contact

Details of person of authority

5 Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

6 Position held

7 Phone number

Email

State/territory details

Details of the state/territory participating in the Pharmaceutical Reforms

8 State/territory

9 Department name

10 Department address

Postcode

11 Department phone number

State/territory government contact

12 Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

13 Position held

14 Phone number

Email

Declaration

This declaration is to be completed by a person of authority from the state/territory government.

15 **I declare that**:

- I am authorised to provide these details on behalf of the hospital authority.
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Name

Signature

Date

/ /

Position held

Phone number

Email

Clear form Print form