First Aid Permit Application Form

*Medicines and Poisons Act 2014*

Table of Contents

[INSTRUCTIONS and INFORMATION i](#_Toc97897015)

[PART 1: APPLICATION for a FIRST AID PERMIT 1](#_Toc97897016)

[1. Details of applicant (nominated Permit holder) 1](#_Toc97897017)

[2. Permits issued to a corporation or partnership 2](#_Toc97897018)

[3. Premises and building security details 2](#_Toc97897019)

[4. Schedule 2 and 3 medicines required, storage and access 3](#_Toc97897020)

[5. Clinical protocols 4](#_Toc97897021)

[6. Standard operating procedures 4](#_Toc97897022)

[7. Multiple premises 5](#_Toc97897023)

[8. Declaration by applicant to obtain a Permit 5](#_Toc97897024)

[PART 2: PERSONAL INFORMATION: APPLICANT 6](#_Toc97897025)

[9. Identification of individual applicant 6](#_Toc97897026)

[10. Qualifications and experience of applicant applying as an individual person 6](#_Toc97897027)

[11. Prior licences/permits for medicines/poisons held by applicant 7](#_Toc97897028)

[12. Criminal check for applicant 7](#_Toc97897029)

[13. Financial resources of applicant 7](#_Toc97897030)

[14. Declaration by applicant 8](#_Toc97897031)

[PART 3: PERSONAL INFORMATION: RESPONSIBLE PERSON 9](#_Toc97897032)

[15. Identification of responsible person 9](#_Toc97897033)

[16. Qualifications of person responsible for a premises 9](#_Toc97897034)

[17. Prior licences/permits for medicines/poisons held by responsible person 10](#_Toc97897035)

[18. Criminal check for responsible person 10](#_Toc97897036)

[19. Declaration by responsible person 10](#_Toc97897037)

[PART 4: Payment and Checklist 11](#_Toc97897038)

[20. Payment: 11](#_Toc97897039)

[21. Checklist 12](#_Toc97897040)

[Part 5: Appendix 13](#_Toc97897041)

[Appendix A: Certifying true copies of photographic identification 13](#_Toc97897042)

|  |  |
| --- | --- |
| INSTRUCTIONS and INFORMATION | |
|  | This application form is for a new **First Aid Permit** to obtain medicines in Schedule 2 (pharmacy medicine) and Schedule 3 (pharmacist only medicine) to provide first aid treatment at a workplace for staff or clients.  If small quantities of Schedule 2 and 3 medicines are required, these can be purchased from a retail pharmacy without a permit. A permit is only required if larger quantities of these medicines need to be purchased from a licensed medicines wholesaler.  If a more extensive range of medicines is required, including any prescription (Schedule 4) medicines, an application should be made (by a medical practitioner) for a Health Service Permit for Medical Treatment.  If first aid treatment is required at events and Schedule 2 and 3 medicines will be transported from the storage address to these events, please apply for a Health Service Permit for an Ambulance Service.  This application form **MUST** be completed by the nominated applicant who will be:   * the individual permit holder or * a corporate officer, if the permit is being issued to a body corporate or * a partner, if the permit is to be issued to a partnership   The applicant must be suitably qualified and understand the requirements and terminology contained in this application form.  **All communication will ONLY be with the nominated Permit holder, corporate officer or partner.**  This application refers to the term “business” which also includes an organisation or government entity.  To request a change to an existing permit, please complete an Application to Change a First Aid Permit, found at: [Application forms for Licences and Permits](https://ww2.health.wa.gov.au/Articles/A_E/Application-forms-for-Licences-and-Permits)  There are five parts to this form:  Part 1: Application form for a First Aid Permit.  Part 2: Personal Information: Identification, Fitness and Probity to be completed by the nominated applicant.  Part 3: Personal Information: Identification, Fitness and Probity to be completed by the nominated responsible person.  Part 4: Payment and checklist.  Part 5: Appendix |
|  | **Permit holder and qualifications and/or experience**  **2.1** **Permits can be issued to:**   1. Individual applicants, who must:    * complete Part 2: Personal Information: Identification, Fitness and Probity and sign the declaration about personal information at Part 2 Section 17,    * be a medical practitioner, nurse practitioner, registered nurse or registered paramedic or a person with a relevant qualification and/or experience handling the Schedule 2 and 3 medicines on the Permit    * be the most senior person responsible for providing first aid at the premises and   have authority in the business, organisation or government entity to determine policies and procedures for management of the medicines. **or**   1. Body corporate (corporation) or partnership where:    * each corporate officer (directors, company secretary, chief executive officer, general manager and chief financial officer) or each partner must complete Part 2: Personal Information: Identification, Fitness and Probity and sign the declaration about personal information at Part 2 Section 17.    1. **Permits issued to a corporation or partnership**   The corporation or partnership:   * must always employ a Medical Director or Clinical Director who is a medical practitioner, registered nurse, paramedic or a person with a relevant qualification and/or experience handling Schedule 2 and 3 medicines, who:   + is the most senior person responsible for providing first aid at the premises and   + has authority in the business, organisation or government entity to determine policies and procedures for management of the medicines.   1. **Permit holder responsibilities**   If the Permit is issued, it is the responsibility of the applicant (Permit holder) to ensure compliance with the *Medicines and Poisons Act 2014* and Regulations 2016 and any conditions placed on the Permit.  The Permit holder must also consider whether they have capacity to ensure compliance with the *Medicines and Poisons Act 2014* and Regulations 2016 and compliance with conditions placed on the Permit for every premises listed on the Permit. The Department may request further information in relation to this capacity.  The Permit holder should review standard operating procedures used by the business, organisation or government entity to check they are consistent with the mandatory requirements of the legislation and any conditions placed on the Permit.  There are penalties under the Act for providing false or misleading information when applying for a Permit. |
|  | **Person responsible for a premises and qualifications and/or experience.**  An individual person must also be nominated to have overall responsibility for each premises to be included on the Permit. The role of the responsible person is to manage the medicines on a day to day basis and be the contact person if the Permit holder is not available.  The responsible person for a premises must:   * be employed or contracted by the Permit holder * reside in WA * complete Part 3: Personal Information: Identification, Fitness and Probity * sign the declaration at Section 22.   **3.1** **Responsible person for a Permit issued to an individual person:**  The responsible person for a premises when a Permit is issued to an individual person can be:   1. the Permit holder, only if, the permit is issued to an individual person and not a corporation or partnership,   **or**   1. the most senior person medical practitioner, nurse practitioner, registered nurse, registered paramedic or other suitably qualified person at the premises.    1. **Responsible person for a Permit issued to a corporation or partnership**   The responsible person for a premises when a Permit is issued to a corporation or partnership can be:   1. the most senior person (medical practitioner, nurse practitioner, registered nurse, registered paramedic or other suitably qualified person) at the premises,   **or**   1. the Medical Director (medical practitioner), Clinical Director (nurse practitioner), registered nurse, registered paramedic or other suitably qualified person within the corporation or partnership who has authority to determine policies and procedures in for managing the medicines. Refer to 2.2   Please note: a responsible person must consider whether they have capacity to oversee the day to day management of the medicines at every premises for which they are responsible. Where a single person is responsible for multiple premises, the Department may request further information in relation to this capacity. |
|  | **Standard Operating Procedures (SOPs).**  This application requires the applicant to confirm the business providing first aid has a number of SOPs.  The Department may request that SOPs be made available for auditing purposes.  The issuing of a Permit does not imply approval or otherwise of the SOPs. |

|  |  |
| --- | --- |
|  | **Required documents**  The applicant and responsible person are required to submit copies of certain documents.  If documents are not in English, also attach a translation certified as completed by a National Accreditation Authority for Translators and Interpreters (NAATI) accredited translator.  Copies of photographic identification documents, such as a driver’s licence or passport must be certified as a true copy. A list of people who can certify copies of documents is found in Appendix A. |
|  | **Signatures**  All signatures must be signed in ink or via a verifiable electronic signature. An electronic signature is only acceptable if the submitted application allows the Department to verify the signature.  A “signature” that is copied and pasted and a “signature” that is the person’s name in a font style resembling handwriting will not be accepted.  The nominated Permit holder must sign the Declaration. If the Permit will be held by a corporation or partnership, a corporate officer or partner must sign the Declaration for a new Permit at Section 11. |
|  | **Issuing a Permit**  Applying for a Permit does not guarantee a Permit will be issued.  An application must be deemed complete and payment received before the application is sent to the approvals team where a desktop risk assessment is conducted by an authorised officer.  The Department assesses each application individually and may decide against issuing a Permit.  If the Permit is issued:   * it will expire 1 year after the date of issue, * a renewal application will be mailed to the postal address approximately 2 months prior to expiry.   + It is the Permit holder’s responsibility to inform the Department if the postal address changes.   If the Permit is not issued:   * the applicant will be provided with details of the reasons in writing, * the yearly Permit fee will be refunded,   the application fee is non-refundable. |
|  | **Processing applications**  Applications will be processed in order of receipt after payment has been processed by Finance, provided the required fee has been paid. To ensure a timely decision about your application, please:   * Complete all required Sections of the application, * **Attach** all requested documentation to the application, * Respond to requests from the Department for additional information as soon as possible, * Make sure appropriate staff are available if the Department needs to conduct a premises inspection, * Please do not submit your application as a digital image (photograph). |
|  | **Extra information**  When applying for a Permit please refer to the: [Guide to applying for a Permit or Licence](https://ww2.health.wa.gov.au/Articles/A_E/Application-forms-for-Licences-and-Permits) |
|  | **Submitting the application**  Please email completed form and other requested documentation to [mprb@health.wa.gov.au](mailto:mprb@health.wa.gov.au) |
| **Incomplete applications may be delayed or returned to the applicant** | |
| **Please keep a copy of the completed application form for reference** | |

|  |
| --- |
| PART 1: APPLICATION for a FIRST AID PERMIT |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Details of applicant (**nominated Permit holder)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Refer to instruction number 2, for information on the requirements for being a Permit holder. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Legal Entity (may be different to business or trading name): | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| Business or trading name: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | |
| Type of Permit (tick which one applies): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual person (on behalf of a business). Complete section 1.1 and 1.3 to 1.6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Body Corporate (corporation) or partnership. Complete Section 1.2 and 1.3 to 1.6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.1** | **Permit to be issued to an individual person** (on behalf of a business) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Which type of health practitioner or health professional is the Permit holder? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Medical Practitioner | | | | | | | Registered Nurse | | | | | | | | | | Registered Paramedic | | | | | | | | | | | | | |
|  | Other, please describe: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
|  | Title: | |  | | Forename/s: | | | | | | |  | | | | | | | | | | | Surname: | |  | | | | |  | |
|  | Postal address: | | | | | | | |  | | | | | | | | Suburb: | | |  | | | | | | Postcode: | |  | |  | |
|  | Telephone: | | | | |  | | | | | | | | Fax: |  | | | | | | Email: | | |  | | | | | |  | |
|  | Position in business: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  |
|  | The applicant must **complete Part 2**: Personal Information: Identification, Fitness and Probity. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.2** | **Corporation or partnership.** Tick which one applies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | **Corporation** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Each corporate officer: directors, company secretary, chief executive officer, general manager and chief financial officer **must complete Part 2:** Personal Information: Identification: Fitness and Probity; and | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | 1.2.1 **Attach** a copy of Current Company Extract from ASIC (with details of company directors and secretary) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | **Partnership** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Each partner **must complete Part 2**: Personal Information: Identification: Fitness and Probity. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Section 2 must be completed if the Permit is to be issued to a corporation or partnership. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.3** | **Business/Trading name** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **If** the business has a Business/Trading Name, **attach** a copy of certificate of Record of Registration for Business Name or Current Business Name Extract (from Australian Securities and Investment Commission [ASIC]). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.4** | **Australian Business Number**: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | |
| **1.5** | **Australian Company Number** (ACN) or Australian **Registered Body Number** (ARBN), if applicable: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **1.6** | **Registered business address of applicant:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Same as postal address shown above or: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Address: | | |  | | | | | | | | | | | | Suburb: | | |  | | | | | | | | Postcode: | |  |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Part 1: Application for a First Aid Permit**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Permits issued to a corporation or partnership | | | | | | | | | | | | | | | | | |
| Is the applicant a corporation or partnership?  No  Yes: complete Section 2.1, 2.2 and 2.3 | | | | | | | | | | | | | | | | | |
| **2.1**  **Check** to confirm the corporation or partnership always employs a person who has: | | | | | | | | | | | | | | | | | |
|  | | | * relevant qualification and/or experience handling the Schedule 2/3 medicines on the Permit and * authority within the business entity to determine policies and procedures in relation to handling the Schedule 2/3 medicines on the Permit. | | | | | | | | | | | | | | |
| **2.2 Name of current employee (who meets the requirements of Section 2.1):** | | | | | | | | | | | | | | | | | |
|  | Title: | | |  | | Forename(s): |  | | | | Surname: | | |  | | |  |
| **2.3 Qualifications** of person employed by corporation or partnership and named at Section 2.2 - check which one applies | | | | | | | | | | | | | | | | | |
|  | | 2.3.1 | | | Registered health practitioner- check which one applies | | | | | | | | | | | | |
|  | | | | | Medical practitioner | | | | Registered nurse | | | Registered paramedic | | | | | |
|  | | | | | AHPRA registration number: | | | | |  | | | Registration expiry date: | |  |  | |
|  | | 2.3.2 | | | Other\*: please describe: | | |  | | | | | | | |  | |
|  | |  | | | **\*Attach** copies of any qualifications and CV which demonstrate your suitability as described in Section 2.1 | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Premises and building security details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Section 3 must be completed for every premises listed on the Permit. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is this premises being acquired from another business that provided first aid to staff and clients? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No  Yes: | | | | Name of previous First Aid provider: | | | | | | | | | | | | |  | | | | | | | | | | | |  | | |
|  | | The Department requires the previous Permit holder at the relocated or new added premises to remove the premises from their Permit. The application to remove the premises from the previous Permit holder’s Permit must be received by the Department prior to adding the relocated or new added premises to your Permit. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3.1** | **Premises details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Premises name (**if** applicable): | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
|  | Premises address: | | | | | | |  | | | | | | | | Suburb: | | |  | | | | | | | Postcode: |  | | |  | |
|  | Telephone: | | | |  | | | | | | | Fax: | | |  | | | | | | | Email: |  | | | | | | |  | |
|  | Date of possession of the premises (settlement date/lease commencement/handover of building): | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |
|  | Note: Permit will be issued with “Valid from” date on or after this date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3.2** | **Person responsible for premises** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Refer to instruction number 3, for information on the requirements for being a responsible person for a premises. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Title: | |  | | | Forename(s): | | | |  | | | | | | | | | | | Surname: | | |  | | | | |  | | |
|  | The nominated responsible person must **complete Part 3**: Personal Information: Identification, Fitness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3.3** | **Location of premises** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Commercial | | | | | | Industrial | | | | | | Rural | | | | | Residential | | | | | | | | | | | | | |
|  | Other-please specify: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | |
| **3.4** | **Building security**: Please check all that apply: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Dedicated monitored alarm system | | | | | | | | | | | | | Video surveillance system (CCTV) | | | | | | | | | | | Motion detectors | | | | | | |
|  | Perimeter fence with lockable gate | | | | | | | | | | | | | Perimeter alarm | | | | | | Other - describe: | | | | |  | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Part 1: Application for a First Aid Permit**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Schedule 2 and 3 medicines required, storage and access | | | | | | | | | | | | | | | | |
| Section 4 must be completed for every premises listed on the Permit. | | | | | | | | | | | | | | | | |
| Premises address: | | | | | |  | | | Suburb: | |  | Postcode: |  |  | |
| Please check which schedule of medicines will be used, check all that apply: | | | | | | | | | | | | | | | | |
| Schedule 2- Pharmacy medicine | | | | | | | | Schedule 3 – Pharmacist only medicine | | | | | | | | |
| **4.1 Please check which medicines are required- check all that apply:** | | | | | | | | | | | | | | | | |
| Adrenaline auto-injectors in Schedule 3 | | | | | | | | | | | | | | | | |
| Glyceryl trinitrate sublingual tablets/sprays in Schedule 3 | | | | | | | | | | | | | | | | |
| Naloxone injection in Schedule 3 | | | | | | | | | | | | | | | | |
| Salbutamol inhalers in Schedule 3 | | | | | | | | | | | | | | | | |
| **4.2 Please list other required medicines** | | | | | | | | | | | | | | | | |
| |  |  |  | | --- | --- | --- | | **Name, strength and form of medicine** | **Schedule** | **Approximate quantity required** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | | | | | | | | | | | | | | | | |
| **4.3 Storage and temperature monitoring of Schedule 2 and 3 medicines** | | | | | | | | | | | | | | | | |
|  | 4.3.1 | | Storage of non-refrigerated Schedule 2/3 medicines (Please check which one applies): | | | | | | | | | | | | | |
|  |  | | Locked room | | | | Locked cupboard | | | | | | | | | |
|  | 4.3.2 | | Will Schedule 2/3 medicines requiring refrigeration be stored at the premises? | | | | | | | | | | | | | |
|  |  | | No | | | | | | | | | | | | | |
|  |  | | Yes: please check how the refrigerated medicines will be stored (Please check which one applies) | | | | | | | | | | | | | |
|  |  | |  | Locked room with refrigerator | | | | | | Locked refrigerator | | | | | | |
|  |  | | | | Please confirm how the temperature of refrigerated Schedule 2/3 medicines will be monitored | | | | | | | | | | | |
|  |  | | | | Vaccine refrigerator with an inbuilt thermometer with downloadable data. | | | | | | | | | | | |
|  |  | | | | Normal refrigerator with temperature data logger that can download data. | | | | | | | | | | | |
|  | | | | | Manual thermometers are not sufficient for continuous monitoring of refrigerated medicines.  The temperature data logger:   * must record multiple data points (not just maximum and minimum temperatures) * must create an alarm if the temperature is outside the designated range. | | | | | | | | | | | |
| **4.4 Access to Schedule 2 and 3 medicines** | | | | | | | | | | | | | | | | |
|  |  | Check to confirm only authorised persons, i.e. individual Permit holders, responsible person or other authorised health practitioners/professionals employed by the business will have unsupervised access to Schedule 2/3 medicines. | | | | | | | | | | | | | | |
| **4.5 Preventing access to Schedule 2 and3 medicines** | | | | | | | | | | | | | | | | |
|  | Please describe how non-authorised staff such as reception staff, cleaners and the public (including family and children) will be prevented from having access to the Schedule 2/3 medicines. | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | |

**Part 1: Application for a First Aid Permit**

|  |  |  |
| --- | --- | --- |
| Clinical protocols | | |
|  | Please confirm the business providing first aid has written clinical protocols for each medicine that is administered to staff, clients and must include the following requirements:   * Name of medicine * Strength of medicine * Form of medicine, e.g. liquid, tablet * Indications for use * Dose of medicine * Dose of medicine for each indication (if applicable) * Contraindications * Common adverse effects * How often the protocols are reviewed * Who reviews the protocols | |
|  | | Please check to confirm that all clinical protocols are available to staff administering the medicine |
|  | | Please check to confirm that the protocols are regularly reviewed by a health professional specialising in medicines |

|  |  |
| --- | --- |
| Standard operating procedures | |
| Please **confirm** the business providing first aid to its staff and clients has the following Standard Operating Procedures: | |
|  | **SOP** used for **ordering** medicines from wholesalers which must support the following requirements: |
| 1. Orders must be approved by the permit holder if the permit is held by an individual on behalf of the business. For permits issued to a partnership or body corporate, the person who signed this application should approve orders for medicines | |
| 1. Only authorised suitably qualified/trained staff should receive medicines when delivered by pharmaceutical wholesalers. Other staff such as administration staff cannot be designated as responsible for this task. | |
| 1. Schedule 2/3 medicines must be ordered from a licensed pharmaceutical wholesaler. | |
|  | |
|  | **SOP** used for **recording** the administration of medicine and storing records which must support the following: |
| 1. A record is made of each medicine administered to each patient. | |
| 1. Adverse effects are recorded. | |
| 1. Records are signed by the staff member who administered the medicine. | |
|  | |
|  | **SOP** for **distribution** of medicines to other premises **if** applicable.SOP must support the following requirements: |
| 1. Schedule 2/3 medicines is only delivered to other premises that are listed on the permit. | |
| 1. Permit holder or appropriate person delegated in writing by the permit holder authorises distribution of stock. | |
| 1. Movement of stock is recorded. | |
| 1. Only authorised suitably qualified/trained staff receive medicines when delivered. | |
| 1. Proof of receipt of delivery is requested and recorded. | |
|  | |
|  | **SOP** that shows **training** is required for staff who will be administering medicines and how the business ensures training is undertaken and remains current. SOP must support the following requirements: |
| 1. At a minimum, training is by a Recognised Training Organisation (RTO). | |
| 1. Currency of training is routinely checked. | |
| 1. Type of training is related to the medicines requested for Permit. | |
|  | |
|  | **SOP** for **stocktakes** and **audits** of medicines, including regular checking for expired stock and disposal of damaged or expired stock. SOP must support the following requirements: |
| 1. Medicines are organised in a manner that makes them easily identifiable and examinable. | |
| 1. Regular stocktakes are scheduled and recorded and expiry date checks are checked. | |
| 1. Short dated medicines are flagged. | |
| 1. Expired and damaged stock are removed and isolated from other stock. | |
| 1. Expired/damaged stock are incinerated by a controlled waste management contractor. | |

**Part 1: Application for a First Aid Permit**

|  |  |
| --- | --- |
| Multiple premises | |
| Will Schedule 2 and 3 medicines be stored at multiple premises under this Permit? | |
| No | |
| Yes: complete Sections 7.1 and 7.2 | |
| 7.1 Will the responsible person for the other premises be the same as the individual Permit holder or a person responsible for the premises named in Section 3.1? | |
|  | Yes |
|  | No: Complete and **attach** Part 3: Personal Information: Identification, Fitness for the nominated responsible person for the other premises. |
| 7.2 Will responses to Sections 5 and 6 be the same for the other premises as for the premises named in Section 3.1 | |
|  | Yes: Complete and **attach** Section 3 and 4 for all other premises. |
|  | No: Complete and **attach** Sections 3,4,5 and 6 for all other premises. |
|  | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Declaration by applicant to obtain a Permit | | | | | | | | | | | | |
| This declaration relates to the application itself and must be signed by the individual applicant or if the Permit is being issued to a corporation or partnership, the declaration must be signed by one of the corporate officers or partners.  Please refer to Instruction 6 for information on acceptable signatures. | | | | | | | | | | | | |
| I (provide full name): | | | |  | | | | | | |  | |
| of (provide full address): | | | |  | | | | | | |  | |
| hereby declare: | | | | | | | | | | | | |
|  | | The information contained in this application form is true and correct. | | | | | | | | | | |
|  | | I am aware that penalties apply under the *Medicines and Poisons Act 2014* for providing false or misleading information in this application. | | | | | | | | | | |
| Signature of applicant: | | |  | | | | | Date: |  | | |  |
| **Witnessed by:** | | | | | | | | | | | | |
|  |  | | | |  |  | | | |  | | |
| (Signature of Witness) | | | | | | | (Name of Witness) | | | | | |

|  |
| --- |
| PART 2: PERSONAL INFORMATION: APPLICANT |

**Part 2** assesses identification, fitness and probity of the Permit holder. If the Permit holder is an individual person,all sections of Part 2 must be completed. If the Permit holder is a corporation or partnership all sections of Part 2 except Section 10 must be completed by each corporate officer or each partner.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Identification of individual applicant | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Refer to instruction number 2, for information on the requirements for being a Permit holder. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **9.1 Personal Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title: | |  | | | Forename/s: | | | | |  | | | | Surname: | | | |  | | | | Date of birth: | | | |  | | | |  |
| Address: | | | |  | | | | | | | | Suburb: | | | |  | | | | | | | Postcode: | | | |  | |  | |
| Postal address: | | | | | |  | | | | | | | Suburb: | | | |  | | | | | | | Postcode: | | | |  |  | |
| Mobile number: | | | | | | |  | | | | | | | | Email: | | | |  | | | | | | | | | |  | |
| Position in business: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | |
| **9.2 Certified true copy of a photographic identification document** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ATTACH** a certified1 copy of a WA State Government or Australian Government issued photographic identification document such as driver’s licence or passport. Non-government issued identification documents will not be accepted. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1Copy of photographic identification document must be certified as a true copy by a person authorised to witness statutory declarations (see Appendix A for a list of persons authorised to certify a true copy). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **9.3 Role in relation to Permit** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | The individual who will hold the Permit on behalf of the business. Complete remainder of Part 2. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | A corporate officer: only applicable if the Permit will be issued to a body corporate. Type of corporate officer: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | Director | | | | | General Manager | | | Company secretary | | | | | | | | | CEO | CFO | | | | COO | | | | | |
|  |  | | Complete Sections 11,12,13 and 14 in Part 2 and **attach** a CV1 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | A partner: only applicable if the Permit will be issued to a partnership | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | Complete Sections 11,12,13 and 14 in Part 2 and **attach** a CV1 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | 1The CV will be used to assess whether each corporate officer or partner meets the requirements of the *Medicines and Poisons ACT 2014.* | | | | | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Qualifications and experience of applicant applying as an individual person | | | | | | | | | | | |
| Complete this section if you are an individual person applying for a Permit.  Do not complete this section, if the Permit is being issued to a corporation and you are a corporate officer, or the Permit is being issued to a partnership and you are a partner. | | | | | | | | | | | |
| Refer to instruction number 2, for information on the requirements for being a Permit holder. | | | | | | | | | | | |
| **10.1** The individual applicant must be a medical practitioner, registered nurse, registered paramedic or other suitably qualified person – check which one applies: | | | | | | | | | | | |
|  | | 10.1.1 | | Registered health practitioner- check which one applies | | | | | | | |
|  | | | | Medical Practitioner | | Registered Nurse | | Registered Paramedic | | | |
|  | | | | AHPRA registration number: | | |  | | Registration expiry date: |  |  |
|  | | | | **Attach** a copy of your currentannual registration certificate or wallet card provided to you by AHPRA.  Note: please **do not** provide an extract of the information available on AHPRA’s public website. | | | | | | | |
|  | | 10.1.2 | | Other: please describe: |  | | | | | |  |
|  | |  | | Please **attach** copies of any qualifications **and** a CV which demonstrate your suitability as a Permit holder for a First Aid Permit. | | | | | | | |
| **10.2 Access to Schedule 2 and 3 medicines and authority within the business** | | | | | | | | | | | |
|  |  | | Check to confirm that you will always have access to the medicines stored at the premises listed on the Permit. | | | | | | | | |
|  |  | | Please check to confirm that, you will have authority within the business to determine policies and procedures in relation to managing the medicines listed on the Permit. | | | | | | | | |

**Part 2: Personal information: Applicant**

|  |  |  |
| --- | --- | --- |
| Prior licences/permits for medicines/poisons held by applicant | | |
| To be completed by the individual applicant, each corporate officer or each partner. | | |
| **11.1** | Have you (or a company of which you were a corporate officer or a partner) previously held a Licence or Permit, under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory, that was suspended or cancelled? | |
|  | No | |
|  | Yes: please provide details of the Licence or Permit number, the name of the business or government entity, when the cancellation or suspension occurred, the reason for the cancellation or suspension and which state or territory the cancellation or suspension occurred in: | |
|  |  |  |
|  |  |  |
|  |  |  |
|  | | |
| **11.2** | Have you (or a company of which you were a corporate officer) ever been refused a Licence or Permit under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory? | |
|  | No | |
|  | Yes: please provide details of the name of the business or government entity, what type of Licence or Permit you applied for, why your application was refused and which state or territory the refusal occurred in: | |
|  |  |  |
|  |  |  |
|  |  |  |
|  | | |

|  |
| --- |
| Criminal check for applicant |
| To be completed by the individual applicant, each corporate officer or each partner. |
| Have you ever been convicted of or are there charges pending for an offence under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory? |
| No |
| Yes: you must **attach** full details in the form of a Statutory Declaration. Your declaration must include the:   * Name of the court including state/territory or country, all relevant dates and any sentences received * The nature of the alleged offence and circumstances surrounding the offences |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Financial resources of applicant | | | | | |
| To be completed by the nominated individual applicant, each corporate officer or each partner. | | | | | |
| **13.1** | Have you been declared bankrupt or a debtor under any bankruptcy law? | | | | |
|  | No | | | | |
|  | Yes: What date was/will your bankruptcy be discharged? |  | |  | |
| **13.2** | Have you ever been a corporate officer of a company that was wound up or subject to an application for, or placed in, receivership or liquidation? | | Yes | | No |
|  | | | | | |

**Part 2: Personal information: Applicant**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Declaration by applicant | | | | | | | |
| This declaration must be signed by the individual applicant, each corporate officer or each partner and includes probity check consent.  Please refer to Instruction 6 for information on acceptable signatures. | | | | | | | |
|  | In accordance with Section 39 of the *Medicines and Poisons Act 2014*, I give consent to the Western Australian Department of Health to carry out all relevant searches to determine my fitness and probity in relation to holding a First Aid Permit. These searches may include (without limitation) corporate searches, checks with health professional registration boards (including registration status and release of information on any current or ongoing investigations) and criminal record checks. I also understand I may be requested to provide further information relevant to determining fitness and probity. | | | | | | |
|  | I am at least 21 years of age. | | | | | | |
|  | The information contained in this application form is true and correct. | | | | | | |
|  | I am aware there are penalties under the *Medicines and Poisons Act 2014* for providing false or misleading information. | | | | | | |
|  | I am aware of my responsibility for the safe storage and use of Schedule 2/3 medicines and will ensure compliance with the *Medicines and Poisons Act 2014* and Medicines and Poisons Regulations 2016, and compliance with conditions placed on the Permit. | | | | | | |
|  | I will notify the Department of Health if I am no longer employed by the business providing first aid, a corporate officer (if the applicant is a corporation) or a partner (if the applicant is a partnership) | | | | | | |
| Signature: | |  | Name: |  | Date: |  |  |
|  | | | | | | | |

|  |
| --- |
| PART 3: PERSONAL INFORMATION: RESPONSIBLE PERSON |

**Part 3** must be completed by the responsible person and assesses identification, fitness and probity

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Identification of responsible person | | | | | | | | | | | | | | | | | | | | | | | | |
| The role of the responsible person is to manage the Schedule 2/3 medicines on a day to day basis and be the contact person, if the Permit holder is not available. | | | | | | | | | | | | | | | | | | | | | | | | |
| Refer to instruction number 3 for information on the requirements for being a responsible person for a premises. | | | | | | | | | | | | | | | | | | | | | | | | |
| **15.1** Will the Permit be issued to an individual person or a corporation or partnership, check which one applies: | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual person | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Will the individual applying to be Permit holder also be responsible for the premises named in Section 2.1? | | | | | | | | | | | | | | | | | | | | | |
|  | | | Yes: Confirm name: | | | | | | | | Forename: |  | | | | Surname: | | |  | | | | |  |
|  | | |  | | There is no requirement to complete Part 3. | | | | | | | | | | | | | | | | | | | |
|  | | | No: complete remainder of Part 3 | | | | | | | | | | | | | | | | | | | | | |
| Corporation or partnership: Complete remainder of Part 3 | | | | | | | | | | | | | | | | | | | | | | | | |
| **15.2 Personal details of responsible person** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Title: | | |  | | Forename: | | | |  | | | | | Surname: | | |  | | Date of birth: | |  | |  |
|  | Postal Address: | | | | | | |  | | | | | Suburb: | | |  | | | | Postcode: |  | | |  |
|  | Mobile number: | | | | | |  | | | | | | | Email: | | |  | | | | | | |  |
|  | Position in business: | | | | | | | |  | | | | | | | | | | | | | |  | |
| **15.3 Certifiedtrue copy of a photographic identification document** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **ATTACH** a certified1 copy of a WA State Government or Australian Government issued photographic identification document such as driver’s licence or passport. Non-government issued identification documents will not be accepted. | | | | | | | | | | | | | | | | | | | | | | |
|  | | 1 Copy of photographic identification document must be certified as a true copy by a person authorised to witness statutory declarations (see Appendix A for a list of persons authorised to certify a true copy). | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Qualifications of person responsible for a premises | | | | | | | | | | |
| Refer to instruction number 3 for information on the requirements for being a responsible person for a premises. | | | | | | | | | | |
| **16.1** Qualifications of responsible person for a premises on a Permit, check which one applies: | | | | | | | | | | |
|  | 16.1.1 | Registered health practitioner- check which one applies | | | | | | | | |
|  | | Medical practitioner | | Registered nurse | | Registered paramedic | | | | |
|  | | AHPRA registration number: | | |  | | Registration expiry date: |  |  | |
|  | | **Attach** a copy of your currentannual registration certificate or wallet card provided to you by AHPRA.  Note: please **do not** provide an extract of the information available on AHPRA’s public website. | | | | | | | | |
|  | 16.1.2 | Other: please describe: |  | | | | | |  |
|  |  | Please **attach** copies of any qualifications and a CV which demonstrate your suitability as a responsible person for a First Aid Permit. | | | | | | | | |
| **16.2** Is the Permit being issued to a corporation or partnership? | | | | | | | | | | |
|  | No | | | | | | | | | |
|  | Yes: You may be asked to provide extra information regarding your qualifications / training /experience. | | | | | | | | | |

**Part 3: Personal information: Responsible Person**

|  |  |  |
| --- | --- | --- |
| Prior licences/permits for medicines/poisons held by responsible person | | |
| **17.1** | Have you (or a company of which you were a corporate officer or a partner) previously held a Permit of Licence, under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory, that was suspended or cancelled? | |
|  | No | |
|  | Yes: please provide details of the Permit or Licence number, the name of the business or government entity, when the cancellation or suspension occurred, the reason for the cancellation or suspension and which state or territory the cancellation or suspension occurred in: | |
|  |  |  |
|  |  |  |
|  |  |  |
|  | | |
| **17.2** | Have you (or a company of which you were a corporate officer) ever been refused a Permit or Licence under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory? | |
|  | No | |
|  | Yes: please provide details of the name of the business or government entity, what type of Permit or Licence you applied for, why your application was refused and which state or territory the refusal occurred in: | |
|  |  |  |
|  |  |  |
|  |  |  |
|  | | |

|  |
| --- |
| Criminal check for responsible person |
| Have you ever been convicted of, or are there charges pending for an offence under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory |
| No |
| Yes: you must **attach** full details in the form of a Statutory Declaration. Your declaration must include the:   * Name of the court including state/territory or country, all relevant dates and any sentences received * The nature of the alleged offence and circumstances surrounding the offences |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Declaration by responsible person | | | | | | |
| This declaration must be signed by the nominated responsible person and includes probity check consent.  Please refer to Instruction 6 for information on acceptable signatures. | | | | | | |
| 1. I acknowledge my role is to manage the Schedule 2 and 3 medicines on a day to day basis and be the contact person, if the Permit holder is not available. | | | | | | |
| 1. I give consent to the Western Australian Department of Health to carry out all relevant searches to determine my fitness and probity to be named as the responsible person on a First Aid Permit These searches may include (without limitation) corporate searches, and criminal record checks. I also understand I may be requested to provide further information relevant to determining fitness and probity. | | | | | | |
| 1. I am at least 21 years of age. | | | | | | |
| 1. The information contained in this application form is true and correct. | | | | | | |
| Signature: |  | Name: |  | Date: |  |  |
|  | | | | | | |

# PART 4: Payment and Checklist

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Payment: | | | | | | | | | | | | | | | | | | |
| **Fee: $380** | | | | | | | | | | | | | | | | | | |
| Comprising a non-refundable application fee of $218 and 1 year Permit fee of $162.  Permit fee only will be refunded if the Permit is not issued. | | | | | | | | | | | | | | | | | | |
| * + 1. Credit Card – American Express and Diners not accepted | | | | | | | | | | | | | | | | | | |
|  | Card type: | | MasterCard | | | | | Visa | | | | | | | | | | |
|  | Name on card: |  | | | | | | | | Card number: |  | | | | | | |  |
|  | Expiry date: |  | | | | | Amount:  **$380** | | | | | | | | | | | |
|  | Signature of cardholder: | | | |  | | | | | | | | | Date: | |  |  | |
|  | | | | | | | | | | | | | | | | | | |
| * + 1. Direct debit to bank | | | | | | | | | | | | | | | | | | |
|  | **Please quote applicant’s name or business name in the reference** | | | | | | | | | | | | | | | | | |
|  | Bank: Commonwealth Bank: | | | | | **BSB**: 066 040 | | | **Account number:** 13300018 | | | | Amount: **$380** | | | | | |
|  | Receipt Number: | | |  | | | | | | | | Payment date: | | |  | |  | |
|  | | | | | | | | | | | | | | | | | | |
| * + 1. Cheque or money order – made payable to DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | |

**Please keep a copy of the completed application form for reference**

Please email completed form and other requested documentation to [mprb@health.wa.gov.au](mailto:mprb@health.wa.gov.au)

Please email completed form and other requested documentation to: [mprb@health.wa.gov.au](mailto:mprb@health.wa.gov.au)

**PART 4: Payment and Checklist**

|  |  |
| --- | --- |
| Checklist | |
| Please ensure all the appropriate requested documentation is attached for: | |
| **Part 1 Application for a First Aid Permit** | |
|  | If the Permit is being issued to a corporation, attach a copy of the Current Company Extract from ASIC (includes details of all company directors and secretary) (Section 1.2.1) |
|  | If the business has a Business or Trading Name, attach a copy of certificate of Record of Registration for Business Name or Current Business Name Extract (Section 1.3) |
|  | If the Permit is being issued to a corporation or partnership and the employee responsible for policy and procedures in regard to Schedule 2/3 medicines is not a relevant health practitioner- attach CV demonstrating suitability via qualifications and/or experience (Section 2.3.2) |
|  | Completed Part 3 Personal Information: Identification, Fitness and Probity for responsible person if different from the Permit holder (Section 3.2) |
|  | Copy of relevant sections **if** there are multiple premises (Section 7) |
|  | Declaration signed and dated by **applicant** (individual Permit holder, corporate officer or partner)(Section 8) |
| **Part 2: Personal information, fitness and probity for applicant (nominated Permit holder) i.e.**  **Individual applicant, each corporate officer or each partner** | |
|  | Copy of photographic identification which must be certified as a true copy by a person authorised to witness statutory declarations (Section 9.2) See Appendix A for a list of persons authorised to certify a true copy. |
|  | If the applicant is a corporation or partnership, attach a CV and copies of qualifications for each corporate officer or partner (Section 9.3) |
|  | If the applicant is a registered health practitioner, attach a copy of the current annual registration certificate or wallet card provided by AHPRA. Do not provide an extract of the information available on AHPRA’s public website. (Section 10.1.1) |
|  | If the applicant is **not** a registered health practitioner, please attach copies of qualifications/training and a CV which demonstrates the applicant’s suitability as a Permit holder for a First Aid Permit. (Section 10.1.2) |
|  | If applicable, a Statutory Declaration relating to an offence under the *Medicines and Poisons Act 2014* or a repealed corresponding law, or a corresponding law in another state or territory (Section 12) |
|  | Declaration about personal information signed by applicant (individual Permit holder, corporate officer or partner) (Section 14) |
| **Part 3: Personal information, fitness and probity for responsible person** | |
|  | Copy of photographic identification which must be certified as a true copy by a person authorised to witness statutory declarations (Section 15.3) See Appendix A for a list of persons authorised to certify a true copy. |
|  | If the responsible person is a registered health practitioner, attach a copy of the current annual registration certificate or wallet card provided by AHPRA. Do not provide an extract of the information available on AHPRA’s public website (Section 16.1.1) |
|  | If the responsible person is **not** a registered health practitioner, attach copies of qualifications/training and a CV which demonstrates the person’s suitability as a responsible person for a premises. (Section 16.1.2) |
|  | If applicable, a Statutory Declaration relating to an offence under the *Medicines and Poisons Act 2014* or a repealed corresponding law or corresponding law in another state or territory (Section 18) |
|  | Declaration about personal information signed by responsible person (Section 19) |
| **Part 4: Declaration and Payment** | |
|  | Payment details completed with correct signature if paying by credit card (Section 20) |

# Part 5: Appendix

## 

## Appendix A: Certifying true copies of photographic identification

Suggested wording for certification is as follows:

I certify that this appears to be a true copy of the document produced to me on <date>

Signature

Name

Profession or occupation group

| **Persons who can certify documents** | |
| --- | --- |
| Academic (tertiary institution) | Medical practitioner |
| Accountant | Member of Parliament |
| Architect | Minister of religion |
| Australian Consular Officer | Nurse |
| Australian Diplomatic Officer | Optometrist |
| Bailiff | Patent attorney |
| Bank manager | Pharmacist |
| Chartered secretary | Physiotherapist |
| Chiropractor | Podiatrist |
| Company auditor or liquidator | Police officer |
| Court officer (judge, master, magistrate, registrar or clerk) | Post Office manager |
| Defence Force officer | Psychologist |
| Dentist | Public servant |
| Engineer | Public notary |
| Industrial organisation secretary | Real Estate agent |
| Insurance broker | Settlement agent |
| Justice of the Peace | Sheriff or deputy Sheriff |
| Lawyer | Surveyor |
| Local government CEO or deputy CEO | Teacher |
| Local government councillor | Tribunal officer |
| Loss adjuster | Veterinarian |
| Marriage celebrant |  |