



Application Form

CHANGE OF PHARMACY OWNERSHIP where the purchasers are a PARTNERSHIP OF PHARMACISTS

Application fee: \$550.00 for each new financial interest

To be completed by the **purchaser/s** of the pharmacy and must be lodged with the Pharmacy Council of New South Wales ('the Council') at least **14 days before** the interest is acquired.

This application should be completed with reference to '**The Guide,**' the *Health Practitioner Regulation National Law (NSW)* ('the Law') and the *Health Practitioner Regulation (NSW) Regulation 2010* ('the Regulation').

All documentation must be received by the **lodgement date** for the application to be considered at the next Council Meeting. Lodgement and meeting dates can be found on the Council's website.

A '**Notice of Completion**' must be lodged with Council within 14 days of completion the sale.

Vendors must submit a 'Notice of Disposal of Financial Interest in a Pharmacy' within 14 days of selling/transferring the interest.

EXISTING PHARMACY DETAILS AS ON THE REGISTER

Pharmacy Name _____

Pharmacy Registration No. _____ PC _____

[see Guide Note 2 'Definitions - Pharmacy Registration Numbers']

Are you changing the name of the Pharmacy? Yes*

*If **yes** please also attach an application for 'Change of Pharmacy Name' No

Pharmacy street address _____

Postcode _____

PROPOSED PHARMACY CONTACT DETAILS

Telephone () _____ Facsimile () _____

Pharmacy Email _____

Postal Address _____

CONTACT FOR THIS APPLICATION

Name _____

Email _____ Tel _____

CURRENT OWNER/S

Current ownership: Sole owner/pharmacist Partnership Pharmacists' Body Corporate

Details of all current owners/members of a pharmacist body corporate to be completed. If more than six pharmacists, please attach a separate schedule.

Pharmacist 1:

Full Name _____ PHA _____

Sole owner/pharmacist Partner Member of Pharmacists' Body Corporate

Name of Pharmacists' Body Corporate _____

Pharmacist 2:

Full Name _____ PHA _____

Partner Member of Pharmacists' Body Corporate

Name of Pharmacists' Body Corporate _____

Pharmacist 3:

Full Name _____ PHA _____

Partner Member of Pharmacists' Body Corporate

Name of Pharmacists' Body Corporate _____

Pharmacist 4:

Full Name _____ PHA _____

Partner Member of Pharmacists' Body Corporate

Name of Pharmacists' Body Corporate _____

Pharmacist 5:

Full Name _____ PHA _____

Partner Member of Pharmacists' Body Corporate

Name of Pharmacists' Body Corporate _____

Pharmacist 6:

Full Name _____ PHA _____

Partner Member of Pharmacists' Body Corporate

Name of Pharmacists' Body Corporate _____

1. PHARMACY OWNERSHIP DETAILS TO BE REGISTERED

Note: If the new ownership structure includes a partnership of pharmacists and one or more Pharmacists Body Corporates, **do not use this form**. An application for *Change of Ownership where the new ownership structure includes a Pharmacists Body Corporate* must be used.

1.1 Partnership of pharmacists

[See Guide Note 4 "Pharmacists' Partnership"]

Number of pharmacists in the partnership _____
(Partnership Agreement must be attached see 7 - 'Document Schedule')

*If more than six pharmacists please attach a separate schedule.

Pharmacist 1:

Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes
No

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 2:

Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes
No

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 3:
Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes
No

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 4:
Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes
No

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 5:
Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes
No

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 6:
Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes
No

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

2. ESTABLISHMENT DETAILS

The Law and the Regulation allows the Council access to relevant documentation for the purchase of a pharmacy. This section requires the disclosure of prescribed documents detailing the financial and other arrangements for the conduct of the pharmacy business.

2.1 Contract of sale/purchase agreement

Is there a signed exchanged Contract of Sale or Purchase Agreement? Yes No

If yes, it must be attached (See 7 - 'Document Schedule').

2.2 Details of Finance/ Contributions

[see Guide Note 9 'Financial Arrangements']

(Loan/Finance Agreement/documentation & Statutory Declaration (if applicable) must be attached, see 7 - 'Document Schedule')

Pharmacist 1:
Personal Contribution* \$ _____

Name of Finance Lender _____ \$ _____

Pharmacist 2:
Personal Contribution* \$ _____

Name of Finance Lender _____ \$ _____

Pharmacist 3:
Personal Contribution* \$ _____

Name of Finance Lender _____ \$ _____

Pharmacist 4:
Personal Contribution* \$ _____

Name of Finance Lender _____ \$ _____

Pharmacist 5:
Personal Contribution* \$ _____

Name of Finance Lender _____ \$ _____

Pharmacist 6:
Personal Contribution* \$ _____

Name of Finance Lender _____ \$ _____

Total Finance \$ _____

* a statutory declaration must be completed and attached wherever an applicant is contributing to the cost of finance through his or her own funds (see Annexure A).

See Guide Note 9 'Financial Arrangements' for more information about completing the statutory declaration including who may act as witness to a statutory declaration in NSW.

3. DETAILS OF LEASE OF PREMISES

[Lease agreement of premises/transfer of lease document must be attached, see 7 - 'Document Schedule']

- 3.1 Will the pharmacy premises be leased? Yes
No (Go to 3.8)
- 3.2 Is this a new lease? Yes
No
- 3.3 Is this a transfer of an existing lease? Yes
No
- 3.4 Is the lease a sub-lease? Yes
[see Guide Note 10 'Lease of Premises'] No

3.5 Complete the following lease details (details of the new or transferred lease):

Head Lessor Name _____

Lessor Name _____
(sub-lease)

Lessee Name(s) _____

3.6 What is the expiry date of this lease? _____

- 3.7 Does the lease have a percentage of turnover clause? Yes
[see Guide Note 10 'Lease of Premises'] No

Note: Any provision or clause in a lease agreement which provides that the lessor is to receive money, or other consideration, that varies according to the turnover of the pharmacy, is **void**.

3.8 Other arrangement or understanding whether formal or informal, whether express or implied (please specify) and attach information explaining the arrangement)

4. PROFESSIONAL SERVICES ROOM

Are you intending to establish a Professional Services Room associated with this pharmacy?
[Professional Service Rooms are approved premises associated with, but separate to, the pharmacy and are limited to preparation and packaging, see Guide Note 13 'Professional Services Room Requirements']

Yes*
No

*If **yes** please also attach an application for 'Professional Services Room'.

5. SERVICE ENTITIES

5.1 Will a Service Entity be operating in association with this pharmacy?

[See Guide Note 7 'Service Entities']

Yes
No (Go to 6)

5.2 Service Entity name _____

ABN _____ ACN _____

5.3 What form is this Service Entity?

(e.g. Trust, Service Company etc) _____

5.4 If a Trust, what is the name of the Trust?

(Copy of Trust Deed is **not** required) _____

5.5 Is there a Service Agreement?

Yes*
No

(*If **yes** you must attach Service Agreement, see 7- 'Document Schedule' if no, you must attach information explaining the arrangements or understanding, whether formal or informal, whether express or implied)

6. OTHER ARRANGEMENTS

6.1 Franchise / Banner Group

(a) Is this pharmacy to be part of a franchise or banner group?

Yes*
No (Go to 7)

(*If **yes** you must attach Franchise or Banner Group Agreement, see 7 - 'Document Schedule')

(b) Will this arrangement involve a Licence Agreement or Management Services Agreement?

Yes*
No

(*If **yes** attach Licence Agreement or Management Services Agreement, see 7 - 'Document Schedule')

Note: Any provision or clause in a licence agreement which provides that the lessor is to receive money, or other consideration, that varies according to the turnover of the pharmacy, is **void**.

7. DOCUMENTS REQUIRED

The Law permits the Council to request copies of any documents in support of this application. All relevant documents in the schedule below are to be lodged together with this application.

Any unsigned documentation will not be accepted.

DOCUMENT SCHEDULE

(Please tick)

Document description	Document Attached	Not Applicable
Partnership Agreement	<input type="checkbox"/>	<input type="checkbox"/>
Contract of Sale/Purchase Agreement	<input type="checkbox"/>	<input type="checkbox"/>
Loan/Finance Agreement	<input type="checkbox"/>	<input type="checkbox"/>
Statutory Declaration (Annexure A)	<input type="checkbox"/>	<input type="checkbox"/>
Lease agreement of premises/Transfer of lease	<input type="checkbox"/>	<input type="checkbox"/>
Service Agreement	<input type="checkbox"/>	<input type="checkbox"/>
Franchise/Banner Group Agreement	<input type="checkbox"/>	<input type="checkbox"/>
Licence/Management Services Agreement	<input type="checkbox"/>	<input type="checkbox"/>
Any other agreement, arrangement information or details required to be attached to/included with this form.	<input type="checkbox"/>	<input type="checkbox"/>

8. CONSIDERATION OF APPLICATION BY COUNCIL

All Applications are subject to Council approval. Completed Applications will be considered at the next monthly Council Meeting.

Incomplete applications: An application that remains incomplete, or not listed for approval, within 3 Council meetings of the lodgement, will be considered withdrawn, and a new application and fee will need to be lodged.

The Council Secretariat can be telephoned **after 11am on the day following** the meeting in order to find out the outcome of the application. Correspondence in respect of approvals will be mailed within **10 working days** of the Council Meeting.

Note: Following confirmation of approval, it is the applicant's responsibility to notify the Department of Human Services/Medicare Services.

A **Notice of Completion** must be lodged following settlement or transfer of ownership of a pharmacy business. The register of pharmacies will only be updated on receipt of the Notice of Completion.

9. SIGNATURES AND DECLARATIONS

All pharmacists either purchasing or retaining a financial interest in the pharmacy must sign.

The following signatures are a declaration by the pharmacist(s) that the information provided in this application is correct and complete. The provision of information you know to be incorrect or incomplete may constitute unsatisfactory professional conduct.

Pharmacist 1:
Full Name _____ PHA _____

Signature _____ Date _____

Witness:
Full Name _____

Signature _____ Date _____

Pharmacist 2:
Full Name _____ PHA _____

Signature _____ Date _____

Witness:
Full Name _____

Signature _____ Date _____

Pharmacist 3:
Full Name _____ PHA _____

Signature _____ Date _____

Witness:
Full Name _____

Signature _____ Date _____

Pharmacist 4:
Full Name _____ PHA _____

Signature _____ Date _____

Witness:
Full Name _____

Signature _____ Date _____

Pharmacist 5:
Full Name _____ PHA _____
Signature _____ Date _____

Witness:
Full Name _____
Signature _____ Date _____

Pharmacist 6:
Full Name _____ PHA _____
Signature _____ Date _____

Witness:
Full Name _____
Signature _____ Date _____

Note: Vendors must submit a 'Notice of Disposal of Financial Interest in a Pharmacy' if fully disposing of their interest in this pharmacy. Such Notice must be lodged within 14 days of selling/transferring the interest.

Application for Change of Pharmacy Ownership / Partnership Payment

Under Division 81 of the Goods and Services Tax Regulation, the Treasurer has determined that the application fee is exempt from the Goods and Services Tax (GST).

Application fee: \$550.00 for each new financial interest

Cheque Made payable to the **Pharmacy Council of New South Wales**

Credit Card Complete details below

Name on the card _____

Cardholder's signature _____

Visa MasterCard

Card Number

Expiry date ____ / ____ Amount \$ _____ Date _____
(Please insert amount to be debited)

We accept Visa or MasterCard only.

Statutory Declaration
OATHS ACT 1900, NSW, NINTH SCHEDULE

I, of
[name of declarant] [residence]

do hereby solemnly declare and affirm that

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[the facts to be stated according to the declarant’s knowledge, belief, or information, severally]

And I make this solemn declaration, as to the matter (or matters) aforesaid, according to the law in this behalf made – and subject to the punishment by law provided for any willfully false statement in any such declaration.

Declared at: on
[place] [date]

.....
[signature of declarant]

in the presence of an authorised witness, who states:

I, a
[name of authorised witness] [qualification of authorised witness]

certify the following matters concerning the making of this statutory declaration by the person who made it: [* please cross out any text that does not apply]

- 1. *I saw the face of the person OR *I did not see the face of the person because the person was wearing a face covering, but I am satisfied that the person had a special justification for not removing the covering, and
- 2. *I have known the person for at least 12 months OR *I have confirmed the person’s identity using an identification document and the document I relied on was

[describe identification document relied on]

..... [signature of authorised witness] [date]