PV Version 7 February 2024	TASMANIAN PHARMACY AUTHORITY Email: registrar@pharmacyauthority.tas.gov.au Telephone: 0417 752 348 ABN 34 562 572 269

Application for assessment of a VACCINATION AREA in a pharmacy business premises

Pursuant to section 71E of the Pharmacy Control Act 2001

This form is to be used if:	You are proposing to use an existing space in an approved and registered pharmacy business premise to offer vaccination services.
This form should **not** be used if:	You are proposing to alter the pharmacy premises, such as to add/construct a new consultation/vaccination room. In this instance you must complete Form PA (Application for Alterations)
The fee for this application is:	NIL fee units

If you have any questions, please phone the Registrar.

Completed forms should be emailed to the registrar@pharmacyauthority.tas.gov.au for consideration by the Tasmanian Pharmacy Authority. For consideration at the next meeting, forms must be submitted not later than ten days prior to the meeting date. Meetings are generally held on the first Wednesday of each month.

Incomplete forms will be returned, which may delay the outcome.

FALSE DECLARATION

A person found guilty of making a false or misleading statement is guilty of an offence and is liable to a penalty of up to 100 penalty units (Section 68, Pharmacy Control Act 2001)

PERSONAL INFORMATION PROTECTION STATEMENT

Personal information will be collected from you by the Tasmanian Pharmacy Authority for the purpose of administering the ownership and registration of Tasmanian pharmacy business premises. Your personal information will be used for the primary purpose for which it is collected and may be disclosed to contractors and agents of the Tasmanian Pharmacy Authority, law enforcement agencies, Medicare Australia, the Australian Health Practitioner Regulation Agency, the Pharmaceutical Services Branch of the Department of Health and Human Services, courts and other organisations authorised to collect it. Your personal information will be managed in accordance with the Personal Information Protection Act 2004. You may access your personal information on written request to the Tasmanian Pharmacy Authority. You may be charged a fee for this service.

1. The Pharmacy

1.1 Owner(s) Please list the name and email address of each owner of this business ie the holder(s) of the Eligibility Certificate (these may be individuals or body corporates). If more space is required, please append additional pages.

Name	Email

1.2 Premises

Pharmacy Name	
Address	
Phone	Fax
Email	
TPA identifier PY	

1.3 Contact Details – for all correspondence in relation to this application; this must be an Owner or pharmacist-in-charge

Name
Phone
Email

2. Proposed Vaccination Area

The approved vaccination area must comply with all requirements of the current versions of the following:

- Pharmacy Control Act 2001,
- the Tasmanian Pharmacy Authority Guidelines,
- the Poisons Act 1971 and Poisons Regulations 2018,
- Immunisation Program Guidelines as issued by the Department of Health Tasmania,
- the Australian Immunisation Handbook, and
- Pharmaceutical Society of Australia Professional Practice Standards.

It is the obligation of the pharmacy owner to ensure all these requirements are met.

2.1 Please confirm that your proposed vaccination area offers the following:

	√
An area that can be kept clean and tidy, which is sanitised between clients	
A minimum dimension of 2000mm at any point	
A minimum available (free of equipment or furniture) floor area of $4m^2$	
Privacy for sound ie full height walls	
Visual privacy	
A lockable door – either sliding cavity or outwards opening	
Access for clients with a disability	
Three seats (for the client, a carer and the vaccinator) or two seats and a bed	
Sufficient floor space to provide first aid to an unconscious casualty	
A desk or similar	
Sufficient storage for all necessary equipment and records/documents	
Hand washing and/or hand sanitation facilities	
A sharps disposal bin stored a minimum of 1300mm from the floor	
An anaphylaxis kit	
Medical waste bin	
Access to a designated vaccination refrigerator, which:	
- is monitored manually twice daily	
-contains a data logger for continuous temperature recording	
Access to cold chain contingency equipment ie Ice blocks, cooler/eski and a maximum/minimum thermometer and/or UPS for refrigerator power supply	
Privacy and security of any/all client records stored there or as relevant for the day's appointments	
Seating in close proximity and in line of sight of the dispensary for post-vaccination observation, in addition to seating for patients waiting for other reasons	
Will not be used for the storage of scheduled medicines or other goods	
Will not be used for the preparation or storage of dose administration aids and associated items	

3. Floor Plan

You must attach a floor plan of the pharmacy premises, professionally drawn to scale to enable assessment of your application.

This floor plan must include the following details:

	√
The entire approved premises	
The location of any doors, windows and skylights	
The location, dimensions and area of the dispensary	
The boundary of the dispensary	
The 4mradius from the dispensary boundary	
The location and dimensions of the vaccination area	
The location of post-vaccination seating	
The location of desks, chairs, bed or other required furniture	
The location of hand washing facilities	
The location of the refrigerator	

4. Additional Information

Please confirm that you understand and undertake that vaccination services will not be provided until the following requirements are met:

	√
The vaccination program must have approval from the Department of Health	
The vaccination program must engage authorised immunisers	
A second suitably qualified/credentialed person must be present and available during all vaccinations and for the period of observation	

5. Declaration

I, _____Ahpra Number _____

Clearly PRINT the name of the Registered Pharmacist making this declaration

Of

_____

Address

Position

_____

Either an Owner of this pharmacy, or the Pharmacist appointed by the Owner(s) to be regularly and usually in charge

At

_____

Name of the Pharmacy

Declare that, to the best of my knowledge and understanding:

a) the information provided in this application is true and correct

b) all vaccination activities undertaken in the pharmacy business premises will comply with all Legislation, Standards and Guidelines as issued from time to time

c) I understand the premises will be inspected from time to time to ensure compliance with this declaration

Signed Date

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