CERTIFICATION OF CONTINUED SUPPORT SERVICE (Form B)

For applications to be valid, all details need to be completed and declarations signed and dated.

Eligible applicant to complete this section and submit with the Progress Report

|  |  |  |
| --- | --- | --- |
| Progress Report Period: | 0-6 months | 6-12 months |

# Applicant Details

|  |  |  |
| --- | --- | --- |
| Name of Approved Community Pharmacy/ Approved Hospital Authority: | Name of Approved Pharmacist/ Approved Hospital Authority Contact | |
|  |  | |
| Eligible Applicant PBS Approval Number: | ABN: | |
|  |  | |
| Address: |  | |
| Physical address | | |
| Suburb | State | Postcode |
| Postal Address: |  | |
| Postal address | | |
| Suburb | State | Postcode |

## Declaration

I confirm that:

* I am providing the Section 100 Support Services to the approved Remote Area Aboriginal Health Service (AHS) named below, as per the approved Program Rules and via arrangements made under Section 100 of the *National Health Act 1953*;
* I have provided support services over the period indicated above and in accordance with an agreed Work Plan with this AHS.

I declare that the information given by me in this application is true and correct.

|  |  |
| --- | --- |
| Signature of Approved Pharmacist/ Approved Hospital Authority contact: | ****Date:**** |
|  |  |
| Full Name: | ****Position**:** |
|  |  |

# Aboriginal Health Service

Chief Executive Officer or Medical Director of Aboriginal Health Service to complete this section

|  |  |
| --- | --- |
| AHS Name: | S100 Approval Number: |
|  |  |

## Declaration

I declare that:

* This Aboriginal Health Service has entered into an agreement with the Pharmacist named above for the provision of Support Services under the s100 supply arrangements of the *National Health Act 1953*;
* The Eligible Applicant provided visits to the Primary Aboriginal Health Service and its Outstation/s on the following dates during this reporting cycle:

|  |  |
| --- | --- |
| Primary AHS name/s100 Approval Number | Visit Date |
|  |  |

|  |  |
| --- | --- |
| Outstation Name | Visit Date |
|  |  |
|  |  |
|  |  |
|  |  |

These services have been provided satisfactorily over the period stated above.

|  |  |
| --- | --- |
| Signature: | |
|  | |
| Full Name: | Date: |
|  |  |

|  |  |
| --- | --- |
| This program is funded by the Australian Government Department of Health as part of the Seventh Community Pharmacy Agreement. | |
|  | CONTACT THE SUPPORT CENTRE: 1800 951 285 | support@ppaonline.com.au |