

APPLICATION FOR PRESCRIBED ALTERATIONS

Privacy statement – please read carefully

We are collecting your personal information under authority of the *Private Health Facilities Act 1999* (Qld) (PHF Act). Queensland Health manages your personal information in accordance with the PHF Act and the *Information Privacy Act 2009* and Privacy Principles. The information is being collected for the purposes of exercising our statutory functions and activities and to ensure that risks arising from the provision of healthcare in a licenced private hospital are appropriately managed. We may receive information about you from a third party. If this information is relevant to our work, we will take reasonable steps to notify you of certain matters about this information. All personal information is securely stored and only accessible by Queensland Health. Your personal information will not be disclosed to any other third parties without consent unless the disclosure is authorised or required by law. If you provide us with the personal information of a third party, please ensure you have the consent of the individual concerned before sharing it with us. For information about how Queensland Health protects your personal information, or to learn about your right to access your own personal information, please see our website at www.health.qld.gov.au/global/privacy.

Section 1 – Licensee details

Name of licensee (as it appears on your licence)

Details of the authorised representative / contact person

Title	First name	Last name	Job title
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Contact mobile phone number

Contact email address (direct)

Section 2 – Private health facility details

Facility/hospital name

Physical street address

Suburb

Postcode

Postal address (if different from above)

Please select hospital type

Section 3 – Request details

Please select the type of proposed changes that you are requesting:

- ☐ Structural alterations to existing building/area
- ☐ Change of function/change to use of an area
- ☐ New works/building
- ☐ Other change

Please provide description of, and rationale for, proposed changes

Building works proposed commencement date

Building works proposed completion date

Please indicate if this will be a staged build?

For staged builds, please explain staging (with timeframes)

Will the works result in a change to bed numbers or types of services provided?

Will patient management be affected by the building works?

If yes, explain including any temporary accommodation arrangements, how patients and visitors will be managed, changes to workflows, or if staffing changes are required etc.

Proposed date of occupancy (commencement of services) of area

Section 4 – Documents to be included with this application

This application must be accompanied by

- ☐ **proof of payment** (a receipt) of the prescribed fee made using the [BPOINT platform](#).
See [Fee list | Queensland Health](#) for the current prescribed fee.
- ☐ **Existing floor plan** of area of works
 - Highlight area of the proposed works
 - The area of proposed works should be shown in context of the department and the relationship to other adjacent areas (entry and escape points, major circulation corridors, lifts and stairs)
 - Diagrammatically show the current traffic flow patterns for staff, patients, services coming in and waste going out

- ☐ **Proposed floor plan** of area of works
- Architectural layout – fully dimensioned
 - Highlight changes
 - Indicate position of all call points, gases, furniture, fittings and equipment which will be in the room on the plan
 - Diagrammatically show the intended traffic flow patterns for staff, patients, services coming in and waste going out following the completion of works.

It is an offence under section 145 of the Private Health Facilities Act 1999 (Qld) to provide false or misleading information.

Section 5 – Declaration

- ☐ I declare that I have the authority to make this application on behalf of the licensee.
- ☐ I declare that, to the best of my knowledge, all information provided in, and with, this application form is true and correct in every detail.
- ☐ I declare that I am aware of the responsibilities under *the Private Health Facilities Act 1999* (Qld), specifically sections 23 and 143A, to notify the Chief Health Officer of any prescribed changes.

Authorised representative

Title	First name	Last name	Job title
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Signature of authorised representative			Date (DD/MM/YYYY)
<input type="text"/>			<input type="text"/>