

APPLICATION TO REPLACE AN APPROVAL

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 matter 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 – Authority holder details

Name of authority holder (as it appears on your approval)

Details of the authorised representative / contact person

Title	Given name	Family name	Job title
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Contact phone number (direct)

Contact email address (direct)

<input type="text"/>	<input type="text"/>
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Section 2 – Private health facility details

Facility/hospital name

Physical street address

Suburb

Postcode

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Postal address (if different from above)

Please select hospital type

Section 3 – Reason for request

Please select the reason that you are requesting a replacement

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.

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 authority holder.
- I declare that, to the best of my knowledge, all information provided in, and with, this 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	Given name	Family 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"/>