

APPLICATION TO CHANGE A LICENCE TO OPERATE

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 – Licensee details

Name of licensee (as it appears on your licence)

Details of the authorised representative

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

NOTE: If there has been a change to any of the following, a [notification form](#) must be submitted separately to this application (available online).

- day-to-day manager
- nurse in charge
- chief executive, director, or other officeholder of a licensee / approval holder (authority holder) company
- the ownership or major shareholders of a licensee company, including changes to the ultimate parent company
- the licensee's / approval holder's (authority holder's) address
- if a natural person – the name of the licensee / approval holder (authority holder) or an associate of the licensee / approval holder (authority holder)
- the organisation that conducts the hospital's accreditation
- the timing of the hospital's accreditation assessments

A [notification form](#) must also be submitted if any of the following have occurred:

- a licensee / approval holder (authority holder) has been affected by bankruptcy action or control action
- a licensee / approval holder (authority holder), an associate of an authority holder or an executive officer of a corporate authority holder has been convicted of an indictable offence or an offence against a corresponding law
- the equivalent of an authority (approval or licence) under a corresponding law is suspended or cancelled

- a licensee / approval holder (authority holder) has died

Section 3 – Request details

Please select the type/s of proposed changes requested

- ☐ Change to number of beds, cots, bays and / or rooms
- ☐ Addition of new clinical services
- ☐ Increase in level of service that is being provided
- ☐ Removal of clinical services and / or decrease in level of services provided
- ☐ Change to children's age range provided
- ☐ Change to facility name
Please specify new name
- ☐ Change to physical street address of facility
Please specify new address
- ☐ Change to the type of facility – day or private
Please select new facility type
- ☐ Other change – please provide relevant information

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](#) which is available [online](#) (see [Fee list | Queensland Health](#) for the current prescribed fee)
- ☐ if changing number of beds, cots, bays and / or rooms, a completed [beds and procedural areas form](#)
- ☐ if changing clinical services and / or level of services provided, a completed **Clinical Services Capability Framework (CSCF)** – [CSCF list of services and levels form](#)
- ☐ if changing clinical services and / or level of services provided, completed **Clinical Services Capability Framework (CSCF) – self-assessment forms** for each individual CSCF service provided at the hospital (available **on request**). Please note you must contact the Private Health Regulation Unit and request these forms prior to submission of the application
- ☐ if changing facility name, a current Australian Securities and Investments Commission (**ASIC**) **business name extract** showing approval of facility name (obtained within the past 30 days)

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	Given name	Surname	Position 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"/>