IMPORTANT INFORMATION FOR COMPLETING THIS FORM

Use black or blue ink only and print within the boxes in BLOCK letters.

Please ensure:

- that email & telephone numbers are provided as the Patient Review Panel may be required to contact you
 regarding you application at short notice.
- that all applicants have signed and dated the form in Sections 5 & 6.
- that you have read and are familiar with the Privacy Statement at the bottom of this page.

Please note that failure to comply with any of the above requirements may delay the processing of your application.

Further Information

If you have any questions regarding the completion of this form please contact your Assisted Reproductive Treatment provider in the first instance.

If you have any further questions please contact the Patient Review Panel on (03) 9096 2806 or via email at prp@health.vic.gov.au.

What happens next

Once your application has been received you will be sent a confirmation of receipt by email.

Your application will then be checked for all required information and you will be notified of the next available hearing date that your application can be considered by the Panel and whether your attendance is required.

Once the Panel has made a decision regarding your application, you will be notified within 14 days.

Privacy Statement

The Patient Review Panel collects personal and health information relating to you as part of its role in considering applications for treatment in accordance with the *Assisted Reproductive Treatment Act 2008*. This information is handled in compliance with the *Information Privacy Act 2000* and the *Health Records Act 2001*.

The collection of this information is necessary for the Panel to perform its functions. The Panel's ability to handle and determine your application may be hindered if you do not disclose/provide all relevant information.

All information provided will only be used for the purposes intended. All information will be treated as confidential unless otherwise required by law.

In some circumstances the Panel may discuss your application with your ART provider or disclose information about you to a third party for the purposes of obtaining an opinion/assessment/information about your application. Where it is intended to disclose information to a third party your consent will be sought.

Outcomes of applications will be recorded and reported on in a de-identified statistical form and a copy of the certified decision provided to your ART provider. If a decision of the Panel may be reasonably expected to have a significant impact on the way in which treatment is carried out in Victoria the Panel must provide the Victorian Assisted Reproductive Treatment Authority with a de-identified copy of the decision (you will be advised where this occurs).

The information the Panel holds about you can be accessed by you upon request to the Associate.

GPO Box 4541 MELBOURNE VIC 3001 P. +61 3 9096 2806 E. prp@health.vic.gov.au

CRITERIA NOT MET FOR TREATMENT APPLICATION FORM

For office use only															
Date received D D M M Y Y Case code															
Section 1: Assisted Reproductive Treatment (ART) Provider Please circle ART provider:															
Ballarat IVF	City Babies			City Fertility Centre			Melbourne IVF		Mona		Royal Women's Hospital Andrology				
Other:															
Section 2: Applicant's Details															
Date of Birth	D	D	M	M	Υ	Y		Ti	tle						
First name															
Last name															
Postal address															
Suburb															
State										Postco	de	<u> </u>			
Phone number															
Email address															
Section 3: Applican	nt's I	Parti	ner [Deta	ils (i	f app	olicable)				7				
Date of Birth	D	D	M	M	Υ	Υ	ı	Ti	tle	1 1					
First name															
Last name															
Postal address							i i								
Suburb															
State										Postco	de	<u></u>			
Phone number															
Email address															



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Section 4: Reason Why Criteria Not Met								
Please provide details of why the criteria for ART Treatmen	t has not been met							
		•						
		•						
		•						
		•						
		•						
		•						
Section 5: Applicant's Signature								
	l							
The information provided on this application is true and	d correct							
Signature	5.							
	Date	D D M M Y Y						
Section 6: Applicant's Partner Signature (if applicable)								
The information provided on this application is true and correct								
Signature								
-	Date	D D M M Y Y						

Completed forms can be:

- Scanned and emailed to prp@health.vic.gov.au
- Mailed to:

Patient Review Panel GPO Box 4541 MELBOURNE VIC 3001