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| Schedule 4 – Application for Registration  |
| Health service establishments |

# Section A – Applicant details

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| Full name of applicant (proprietor): |  |
| Name of health service establishment: |  |
| Full postal address of applicant: |  |

## Contact person for the purposes of the application:

|  |  |
| --- | --- |
| Name: |  |
| Mobile: |  |
| Telephone: |  |
| Email: |  |
| **NB:** **If the application relates to the transfer of the certificate of registration to another person, then a Schedule 6 should be used.** |

# Section B – Health service establishment details

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| Name of health service establishment: |  |
| Address of health service establishment: |  |
| Postal address (if different from above): |  |
| Municipality: |  |
| Telephone: |  |

## Kind of health service establishment:

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| The kind of health service establishment for which registration is sought- please mark with ‘x’: |
|  | Private Hospital |
|  | Day Procedure Centre |

|  |  |
| --- | --- |
| Name of health service establishment: |  |

Please write the number of beds in the column of the health service establishment.

|  |  |
| --- | --- |
| Type of medical or speciality service | Number of beds(please write number only) |
| Medical health services |  |
| Surgical health services |  |
| Speciality health services  | Number of beds (please write number only) |
| Alcohol or drug withdrawal (detoxification) |  |
| Bariatric procedures (if not bed specific please indicate “Yes” below) |  |
| Cardiac catheterisation |  |
| Cardiac surgery |  |
| Cataract surgery |  |
| Emergency medicine |  |
| Endoscopy |  |
| Intensive Care |  |
| Liposuction |  |
| Mental Health Services |  |
| Neonatal services |  |
| Neurosurgery |  |
| Obstetrics |  |
| Oncology (chemotherapy) |  |
| Oncology (radiotherapy) |  |
| Oocyte retrieval |  |
| Renal dialysis |  |
| Specialist rehabilitation services |  |
| Speciality health services | Please select either yes or no |
| Anaesthesia | Yes No |
| Paediatric services | Yes No |
| Bariatric procedures | Yes No |
|  |
| Total number of beds |  |

## Owner or tenant details

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| Is the applicant the owner or tenant of the premises- please mark with (x):NB: For mobile health services, this applies to address to be registered. |
|  | Owner |
|  | Tenant |
| If the applicant is not the owner, please state name and address of owner: |
| **Full name of applicant (proprietor):** |  |
| **Name of health service establishment:** |  |
| **Full postal address of applicant:** |  |

# Section C – Signature

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| **In accordance with Section 88(3) of the *Health Services Act 1988*, I have given notice in writing of this application to any other person who has an interest in the land as owner or lessee.**  |
| Name of applicant (in BLOCK LETTERS): |  |
| Signature of applicant: |  |
| Date: |  |

### The application must be accompanied by

1. the prescribed fee (refer to [Private Hospitals – fees](https://www2.health.vic.gov.au/hospitals-and-health-services/private-hospitals/registration-fees) for the current prescribed fee); and
2. the documents listed in the applicable guide. Guides for assisting with the contemplation of applications are available for download from [Private Hospitals – forms](https://www2.health.vic.gov.au/hospitals-and-health-services/private-hospitals/forms-checklists-guides).

### Send the completed form

Please send the signed and completed form by email to Private Hospitals privatehospitals@dhhs.vic.gov.au

or by post to:

The Manager
Private Hospitals
Department of Health and Human Services
GPO Box 4057
MELBOURNE VIC 3001

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