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| Schedule 8 – Application for Approval of Alterations to a Clinical Area |
| Health service establishments |

# Section A – Applicant details

|  |  |
| --- | --- |
| Full name of proprietor: |  |
| Full name of applicant: |  |
| Telephone: |  |
| Facsimile: |  |
| Postal address of applicant: |  |

# Section B – Variation details

## Kind of health service establishment

|  |  |  |
| --- | --- | --- |
| The kind of health service establishment for which alteration is sought. Please mark with an (x) | | |
|  | Private Hospital | |
|  | Day Procedure Centre | |
| Name of health service: | |  |
| Address of health service: | |  |
| Postal address (if different): | |  |
| Municipality: | |  |
| Telephone: | |  |

# Section C – Details of alterations sought

|  |  |
| --- | --- |
| The nature of the alterations to a clinical area sought: |  |
| Details of the alterations to a clinical area sought: |  |
| Certificate of AIP number (if issued): |  |

# Section D – Signature

|  |  |
| --- | --- |
| Name of applicant (in BLOCK LETTERS): |  |
| Signature of applicant: |  |
| Date: |  |

### Send the completed form

Please send the signed and completed form by email to [Private Hospitals](mailto:privatehospitals@dhhs.vic.gov.au) [privatehospitals@dhhs.vic.gov.au](mailto: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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