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| **Statement by Accountant** |
| Health service establishments or Mobile health service  OFFICIAL  |

OFFICIAL

Introduction

The statement by accountant form is completed by the applicant to assist the delegate in deciding the financial capacity of the applicant to carry on the health service establishment.

**Sections 71, 83 and 89 of the Health Services Act 1988(The Act)**refer to the requirement for a financial statement relevant to the different application types. These are Approval in Principle, registration, renewal of registration and variation of registration.

**The Act details the specific requirements for each of these in the following sections:
AIP Section 71 (2)(a),
Registration Section 83 (1)(c)(ii),
Renewal / Variation Section 89 (1)(b)(ii).**

The following statement is to be completed by a certified practicing accountant (CPA) or associate chartered accountant (ACA).

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| Name of health service establishment or mobile health service: |  |
| Name of registered proprietor: |  |
| Accounting practice business name: |  |
| Accountant’s full address: |  |
| Suburb: |  |
| Postcode: |  |
| Please mark with an (x) the appropriate qualification |
|  | Public accountant |
|  | Certified practicing accountant |
|  | Chartered accountant |

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| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_being a certified practicing accountant / associate chartered accountant **[*delete as applicable*]**, have considered all relevant documentation (including current and projected balance sheets, operating statements, statements of changes in equity, cash flow statements, a summary of significant accounting policies and other explanatory notes to and forming part of the financial report) pertaining to the above mentioned proprietor’s / proposed proprietor’s **[*delete as applicable*]** financial affairs in accordance with the auditing standards and auditing guidance statements issued by the relevant accounting bodies in Australia, and have formed an opinion that the applicant has, and is likely to continue to have, the financial capacity to operate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **[*name of health service establishment*]** for the period of 2 (two) years. I have / have not **[*delete as applicable*]** attached any disclaimer, qualification, or reservation applicable to this statement. |
| Name of signatory (in BLOCK LETTERS): |  |
| Signature of accountant: |  | Date |  |

### Send the completed form

Please send the signed and completed form by email the Private Hospitals & Day Procedure Centres Unit at privatehospitals@health.vic.gov.au

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