

|  |
| --- |
| **Statutory Declaration – Fitness and Propriety (REN2)**  |
| Health service establishments or Mobile health services OFFICIAL |

## Who needs to complete this form?

* The person, including partnerships, who is the registered proprietor of a health service establishment, mobile health services; or
* Where the registered proprietor is a company, incorporated association or body corporate, all directors (executive and non-executive), board members or office bearers (as the case may be).

## Instructions on completing the form

* Please type or write your answers in block letters
* Please ensure that you answer all questions
* If you answer “yes” to any questions, you must provide details of the circumstances relating to that answer
	+ Your signature must be witnessed, and the witness must sign the form to indicate that this has occurred and records his or her name

## Privacy statement

The Department of Health (the department) collects this personal information for the purposes of processing and considering an application for renewal of registration under the *Health Services Act 1988* (Vic). The department treats all personal information provided by an individual in support of the application in accordance with the *Information Privacy Act 2000* (Vic) and the *Public Records Act 1973* (Vic). If you provide information about other individuals, you must make them aware that such information will or may be provided as part of the application. Failure to provide some or all the information requested may mean that the application cannot be processed.

Personal information provided in this form may be used within the department and with third parties. The type of third parties to whom disclosure may be made includes service providers or other people or companies identified by you in this form who may assist in verifying statements contained in this form. If the personal information is provided in support of an application by a person, company, incorporated association or body corporate, the department may disclose the personal information contained in this form to other officers of the company, incorporated association, or body corporate. The personal information may also be disclosed as required or permitted by law.

You can request access to or correct the information the department holds about you under the *Freedom of Information Act 1982* (Vic). Please contact privacy.complaints@health.vic.gov.au should you wish to make an application or obtain a copy of the department’s Privacy Policy.

Please complete the following:

|  |  |
| --- | --- |
| Title: |  |
| First name: |  |
| Middle name (if applicable): |  |
| Surname: |  |
| Date of birth: |  |
| Place of birth: |  |
| Full residential address: |  |
| Suburb and Postcode: |  |
| Postal address (if different from above): |  |
| Telephone: |  |
| Mobile: |  |
| Email: |  |
| Please provide details of any former names you may have been known by: |  |

1. Please attach evidence of change of names, such as a copy of a certified marriage certificate.

Please attach evidence of your identity with a certified copy of one of the following:

* a current passport.
* a current driver’s licence; or
	+ a current proof of age card.

 **Certification of a document can be carried out by a Justice of the Peace, Registered Nurse, accountant, bank manager, barrister, solicitor, police officer, registered pharmacist, medical practitioner, dentist, chiropractor, physiotherapist, veterinary surgeon, or optometrist.**

1. Are you registered with the Australian health practitioner regulation agency (Ahpra)?

 **Yes** **No**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **N** | **M** | **W** |  |  |  |  |  |  |  |  |  |  |
| **M** | **E** | **D** |  |  |  |  |  |  |  |  |  |  |

Please provide your applicable Ahpra registration number:

**NMW = Nursing/ Midwifery

MED = Medical Doctors**

1. Are you, or were you previously:
* a proprietor.
* a director of a proprietor company; or
	+ involved in a managerial capacity of any health service establishment?

 **Yes No**

If yes, please provide details of the role/s:

|  |  |  |
| --- | --- | --- |
| **Name of the service:** | **Service location (state):** | **Date (from–to):** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. Are you currently a party in any capacity in either criminal or civil proceedings before a:
* court.
* tribunal; or
	+ other adjudication body, including a professional/registration body?

 **Yes No**

(If yes, please attach details regarding this answer)

------------------------------------------------------------------------------------------------------------------------------------------------

1. Has there ever been a finding of guilt against you for a criminal offence (except a conviction that is spent under any prescribed spent convictions scheme)?

 **Yes No**

(If yes, please attach details regarding this answer)

------------------------------------------------------------------------------------------------------------------------------------------------

1. Have you ever:
* been convicted.
* found guilty; or
	+ been a director or executive officer of a company that has been found guilty of an offence under the *Health Services Act 1988* (Vic) or the *Health Services (Health Service Establishments) Regulations 2013*?

 **Yes No**

(If yes, please attach details regarding this answer)

-----------------------------------------------------------------------------------------------------------------------------------------------

1. Are you or have you ever been declared bankrupt or been the subject of any order under the *Bankruptcy Act 1966* (Commonwealth)?

 **Yes No**

(If yes, please attach details regarding this answer)

-------------------------------------------------------------------------------------------------------------------------------------------------

1. Have you been a director or executive officer of a corporation which became insolvent whilst you were a director or executive officer?

 **Yes No**

(If yes, please attach details regarding this answer)

------------------------------------------------------------------------------------------------------------------------------------------------

1. Have you ever been disqualified from acting as a director or acting in the management of an incorporated association?

 **Yes No**

(If yes, please attach details regarding this answer)

-------------------------------------------------------------------------------------------------------------------------------------------------

1. Have you ever:
* contravened any civil penalty provision under the *Corporations Act 2001* (Commonwealth) or any of its predecessors.
* contravened the *Associations Incorporation Act 1981* (Vic) or any equivalent in another jurisdiction or jurisdictions; or
	+ been found guilty of any offence in relation to corporate or regulatory matters?

 **Yes No**

(If yes, please attach details regarding this answer)

-----------------------------------------------------------------------------------------------------------------------------------------------

## Declaration

|  |  |
| --- | --- |
| I [insert full name of person signing declaration] |  |
| of [insert address] |  |
| am a [insert position/title of applicant e.g., proprietor, partner, director] |  |

I declare that:

1. the information provided in this declaration (including any attachment) is true, complete, and correct.
2. I have read, understood, and agree to the conditional and the associated material contained in this form.
3. I understand that the Department of Health will have the right (but not obliged) to act in reliance upon the contents of this form, including its attachments.
4. the Department of Health is authorised to verify any information provided in this form.
5. I am aware that it is an offence to give false and misleading information or make false and misleading statements and that I may be subject to penalties under section 151 (1) of the *Health Services Act 1988* (Vic).

|  |  |
| --- | --- |
| Signature of declarant: |  |
| Date: |  |
| Signature of witness: |  |
| Name of witness (please print): |  |
| Date: |  |

### Send the completed form

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

|  |
| --- |
| To receive this publication in an accessible format, email the Private Hospitals & Day Procedure Centres Unit <privatehospitals@health.vic.gov.au>.Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne. © State of Victoria, Department of Health May 2022. Available at [Forms, checklists and guidelines for private health services](https://www.health.vic.gov.au/private-health-service-establishments/forms-checklists-and-guidelines-for-private-health-service) <https://www.health.vic.gov.au/private-health-service-establishments/forms-checklists-and-guidelines-for-private-health-service> |