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| **Registration Transfer Checklist** |
| Health service establishments or Mobile health service  OFFICIAL |

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| Facility or Mobile Service name: |  |
| Facility / Business address: |  |

## Current (outgoing) proprietor

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| --- | --- | --- |
| Item | Mark with (x) when complete | If item not completed, please detail why (e.g., document not applicable |
| Schedule 6 – Application for Variation of Registration |  |  |
| Payment of prescribed fee (or copy of receipt of payment) |  |  |

### Proposed (incoming) proprietor

|  |  |  |
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| **Item** | **Mark with (x) when complete** | **If item not completed, please detail why (e.g., document not applicable)** |
| Schedule 6 – Application for Variation of Registration |  |  |
| Payment of prescribed fee (or copy of receipt of payment) |  |  |
| Confirmation of bed numbers for prescribed services |  |  |
| **Please provide the appropriate information required for your kind of entity e.g. A, B or C** | | |
| **A. Natural person (sole trader including partnership)** | | |
| Name and address details |  |  |
| Certificate of registration of business name for new name of facility or mobile health service (if applicable) |  |  |
| **B. Company** | | |
| Certificate of registration of business name for new name of facility or mobile health service (if applicable) |  |  |
| Australian Securities and Investments Commission (ASIC) business name extract obtained in previous one month showing business name holder details |  |  |
| ASIC company extract search obtained in previous one month showing registered company office details and listing all directors and office holders |  |  |
| If subsidiary company, a company structure chart |  |  |
| Directors/board members or office bearers form for Registration |  |  |
| **C. Incorporated Association or other body corporate** | | |
| Registered office of the incorporated association or body corporate |  |  |
| Certificate of Incorporation or other documents |  |  |
| Directors/board members or office bearers form for Registration |  |  |
| Most recent Annual Report or Annual Return |  |  |
| **Probity information** | | |
| Statutory Declaration – Fitness and Propriety |  |  |
| Details of relevant professions qualifications and CV |  |  |
| Police check certificate issued within the last 12 months (original or certified copy) |  |  |
| Statement by accountant for Registration form |  |  |
| Business name extract (if applicable) |  |  |
| Security of tenure over site |  |  |
| **Management and staffing requirements (not required for Mobile health services)** | | |
| Notification of Appointments Form– Director of Nursing, Complaints Officer, Chief Executive Officer and Medical Director |  |  |
| Staffing arrangements (nursing and medical staff) |  |  |
| Organisational chart |  |  |
| Committee Reporting Structure (Include Medical Advisory Committee membership) |  |  |
| **Patient quality and safety requirements** | | |
| Health service protocols for quality and safety (by-laws) |  |  |
| Medical credentialing policy Inc. scope of practice |  |  |
| Admission and discharge systems Inc. patient exclusion criteria |  |  |
| Clinical deterioration policy |  |  |
| Complaints management policy |  |  |
| Infection prevention and control policy |  |  |
| Policy and procedures manual |  |  |
| Open disclosure policy |  |  |
| Clinical risk management program Inc. quality improvement plan |  |  |
| Proof of enrolment in an accreditation program |  |  |
| Evacuation policy |  |  |
| Plans for patient experience and Staff safety culture surveys |  |  |
| Sentinel event reporting |  |  |
| Health Services Permit |  |  |
| System submitting health information data (VAED) |  |  |

**Send form to:**Please complete the checklist and return it with your application to: Private Hospitals & Day Procedure Centres Unit at [privatehospitals@health.vic.gov.au](mailto:privatehospitals@health.vic.gov.au)

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