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

# 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:

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| Name: |  |
| Mobile: |  |
| Telephone: |  |
| Email: |  |
| **Note:** 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: |  |

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

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

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| 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) |  |
| 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 circle either ‘Yes’ or ‘No’ |
| Anaesthesia | Yes No |
| Paediatric services  | Yes No |
| Paediatric services **(specified age must be at least 29 days old and under 18 years old when admitted)** | **\_\_\_\_\_\_\_\_\_\_\_ to 18 years of age** |
| Bariatric procedures | Yes No |
| Total number of beds |  |
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**Owner or tenant details**

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| Is the applicant the owner or tenant of the premises - please mark with (x):Note: 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: |  |

### Provide the following for an application:

1. Email privatehospitals@health.vic.gov.au with the completed Schedule 4 form to request an invoice for payment of the prescribed fee (refer to Private Hospitals – fees <https://www.health.vic.gov.au/private-health-service-establishments/fees-for-private-health-service-establishments> for the current prescribed fee). **Payments must be made electronically**.
2. the documents listed in the applicable guide. Guides for assisting with the contemplation of applications are available for download from <https://www.health.vic.gov.au/private-health-service-establishments/forms-checklists-and-guidelines-for-private-health-service>
Send the completed form

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

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