



Notice

CLOSURE OF PHARMACY

INSTRUCTIONS

When do I use this form? This form is to be lodged with the Pharmacy Council of NSW (the Council) when a pharmacy has ceased trading and closed.

When do I need to lodge this Notice? This Notice must be lodged with the Council within 14 days of closure of the pharmacy. Fines apply for failure to notify the Council within the required timeframe.

Where can I get help in completing this Notice? This Notice should be completed with reference to 'The Guide,' the *Health Practitioner Regulation National Law (NSW)* ('the Law') and the *Health Practitioner Regulation (NSW) Regulation 2010* ('the Regulation'). 'The Guide' is available on the Council's website under the 'Resources' tab at <https://www.pharmacycouncil.nsw.gov.au/>. The services of a lawyer, accountant or pharmacy broker may also assist.

CLOSED PHARMACY DETAILS

Pharmacy Name _____

Pharmacy Registration No _____ PC _____
[see Guide Note 1 'Definitions - Pharmacy Registration Numbers']

Street Address _____
_____ Postcode _____

CONTACT FOR THIS NOTICE

Name _____

Email _____ Tel _____

Date of Closure _____

Reason for Closure (optional)

1 OWNERSHIP DETAILS

Ownership: Sole Owner Partnership Pharmacists' Body Corporate

Name of Pharmacists' Body Corporate (if applicable): _____

2 DECLARATION BY PHARMACIST OWNERS/HOLDERS OF A FINANCIAL INTEREST IN THE (CLOSED) PHARMACY

The following signatures are a declaration by the pharmacist(s), who held a financial interest in the pharmacy immediately prior to its closure, that the information provided is correct and complete. The provision of information you know to be incorrect or incomplete may constitute unsatisfactory professional conduct.

If more than six partners / members of a Pharmacists' Body Corporate, please attach a separate schedule.

Pharmacist 1:

Full Name _____ PHA _____

Signature _____ Date _____

Pharmacist 2:

Full Name _____ PHA _____

Signature _____ Date _____

Pharmacist 3:

Full Name _____ PHA _____

Signature _____ Date _____

Pharmacist 4:

Full Name _____ PHA _____

Signature _____ Date _____

Pharmacist 5:

Full Name _____ PHA _____

Signature _____ Date _____

Pharmacist 6:

Full Name _____ PHA _____

Signature _____ Date _____