

# Pharmacy Registration Board of Western Australia

Level 4, 130 Stirling Street, Perth WA 6000

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## RESPONSIBLE PHARMACIST DECLARATION

**Note, this document must be signed by:**

- The pharmacist who has, or will have, overall responsibility for the pharmacy business.

**Section 57 of the Pharmacy Act 2010 (WA), “Supervision of pharmacy business by pharmacist”, states that the pharmacy business carried on at a pharmacy is carried on under the personal supervision of a pharmacist at all times.**

***As the Responsible Pharmacist, I hereby confirm I am aware of my responsibilities, as outlined below.***

1. ensuring compliance with current statutory obligations and professional and ethical standards;
2. the general security of the premises, including control of the keys or other entry devices and intrusion alarm systems;
3. ensuring the correct supervision of students, provisional and limited registered pharmacists (including interns), dispensary assistants and other pharmacy staff;
4. ensuring that in their absence, another pharmacist assumes these responsibilities for the time being;
5. the maintenance at the premises of the required references and equipment;
6. maintenance of a record of all prescriptions dispensed at, or from, the pharmacy, ensuring such records are secured safely, are dealt with in a confidential manner and are retained for a period of 24 months or 60 months for Schedule 8 prescriptions; and
7. holding general registration as a pharmacist with the Pharmacy Board of Australia, with no Conditions that would impact on their ability to fulfil the responsibilities detailed here.

**I declare that the above statements are true and correct**

\_\_\_\_\_  
**Signed (print name below)**                      **Date**                      **Witness Signature**

\_\_\_\_\_  
**Witness Name**

### **Details of Pharmacy Business**

Name of Pharmacy:
Address of the premises:

*Responsible Pharmacist Declaration*

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**Please note, if the change of Responsible Pharmacist occurs *OUTSIDE* of an application to:**

- Change the pharmacy ownership;
- Relocate a pharmacy business; or
- Establish a pharmacy business,

please complete the information below.

**Details of person appointing the Responsible Pharmacist**

**Full Name:** \_\_\_\_\_

Proprietor or Partner in the pharmacy business:

**OR**

Proprietary Interest Pharmacist in the pharmacy business:

\_\_\_\_\_  
Signature of person making the notification

\_\_\_\_\_  
Date:

***Please provide the following details, as well as a certified copy of a Photo ID, eg Driver's Licence or Passport, for the Responsible Pharmacist:***

**Pharmacist Name:** \_\_\_\_\_

**AHPRA Registration No:** \_\_\_\_\_

**Residential Address:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Mobile #:** \_\_\_\_\_

**Date of Commencement of Appointment:** \_\_\_\_\_

**Send to: PHARMACY REGISTRATION BOARD OF WESTERN AUSTRALIA  
applications\_admin@pharmacyboardwa.com.au**