The Pharmacy Guild of Australia
NSW Branch

NSW PHARMACY NEEDLE AND SYRINGE PROGRAM
REGISTRATION FORM

APPLICATION DETAILS

Pharmacy Name: _____

ABN: _____

Pharmacy Address: _____

_____ Postcode: _____

Phone: _____ Fax: _____

Email: _____

PARTICIPANT AGREEMENT

1. I, _____
   PHARMACIST NAME AND POSITION
   on behalf of _____
   PHARMACY NAME
   agree to participate in the program as described in the Participant Information Statement ('Statement') attached to this form.

2. I agree that the pharmacy has established the professional service in accordance with the policies and procedures outlined in the Program Manual.

3. I agree that the status of the pharmacy's current participation will be confirmed against the Pharmacy Guild of Australia (NSW Branch)'s database. I agree that should the pharmacy be recognised as not having previously participated in the Program, that we may be considered eligible for the one-off incentive payment relating to the establishment of a new participant in the Program.

PHARMACIST NAME	PHARMACIST SIGNATURE	DATE

Please return the completed form to The Pharmacy Guild of Australia using one of the following methods.
A copy of this signed Agreement should be retained by you for your records.

BY FAX	BY EMAIL	BY MAIL
(02) 9467 7151	healthservices@nsw.guild.org.au	NSW Pharmacy Needle and Syringe Program The Pharmacy Guild of Australia (NSW Branch) Locked Bag 2112, St Leonards NSW 1590

Submit Form