Australian Government

Medicare Australia

Australian childhood **immunisation** register

Application to register as an immunisation provider

Instructions

Organisation

Complete Section A, C and D

An organisation applicant is a body responsible for providing immunisation services (eg Council, Health Centre etc.)

Individual

Complete Section B, C and D

An individual applicant is a natural person not operating as an organisation, who provides immunisation services.

Completed forms

The completed registration form must be returned to your state or territory health department for approval as a recognised immunisation provider.

Please use BLOCK letters when completing this form.

Approval (to be completed by state or territory health department)

The state/territory health department recognises this applicant as an immunisation provider for the purpose of the Australian Childhood Immunisation Register (the ACIR), and endorses the registration of the applicant whose details appear on this form.

Signature or affixed stamp

Date registration to commence / /

Please forward this approved form to Medicare Australia, GPO Box M933, Perth WA 6843

Section A

Name of organisation

Contact person

Contact telephone number ( )

Note: If the organisation is a hospital, please indicate whether it is public or private.

Public hospital (please tick) ☐

Private hospital (please tick) ☐

Section B

Title (please tick) Mr ☐ Mrs ☐ Ms ☐ Other

Surname

First name Second initial

Date of birth / /

Contact telephone number ( )

Section C

Business address

Postcode

Postal address

Postcode

Section D

Use this section to record details of the bank account into which you require payments for immunisation information to be made.

Bank/institution

Account name

Account number BSB number

Address of branch

Postcode

Declaration

I hereby authorise Medicare Australia to direct all payments relating to the provision of information to the ACIR by me/by this organisation, to the above named bank account. I declare that, to the best of my knowledge, all information provided is true and correct.

Name (please print)

Signature Date / /

Privacy note

The information provided by you on this form will be used by the Australian Childhood Immunisation Register to identify you as a recognised immunisation provider for the purposes of the Immunisation Register. Its collection is authorised by law. Details of your bank account will be disclosed to the relevant bank institutions to facilitate payment of a claim.

For enquiries in relation to this form, or for more information about the Australian Childhood Immunisation Register, call 1800 653 809

Office use only

Provider number	Date of issue	Operator number	Branch	Signature