Secretary of Health
NSW Ministry of Health
C/o Secretariat - Pharmacotherapy Credentialing Subcommittee
LMB 961
NORTH SYDNEY NSW 2059

ATTENTION: Please print clearly in block letters. The signed and completed form and a copy of your CV should be forwarded to: MOH-PCS@health.nsw.gov.au. **NB:** If you do not receive confirmation of receipt of your email within 3 working days, please resend.

Application for Accreditation to Prescribe Opioid Pharmacotherapies

I wish to formally apply under the statutory requirements of the *NSW Poisons and Therapeutic Goods Act 1966*, to be accredited to prescribe opioid pharmacotherapies for the treatment of opioid dependence.
I understand that a prerequisite for approval is the successful completion of the Opioid Treatment Accreditation Course and demonstrated clinical competence in pharmacotherapy treatment.

I completed the Opioid Treatment Accreditation Course on _____/_____/_____

I have attached my Curriculum Vitae, which details my qualifications, employment history and other information relevant to my application.

Prescriber number _____

Australian Health Practitioner Regulation Agency (AHPRA) Registration number _____

AHPRA specialty _____

HPI-I (Healthcare Provider Identifier Individual) number, (if known) _____

I understand that my application and supporting papers will be forwarded to the Pharmacotherapy Credentialing Subcommittee (PCS), and that my name will be passed to the NSW Ministry of Health Pharmaceutical Regulatory Unit (PRU); the Health Care Complaints Commission (HCCC) for advice as to any matters under investigation; the Australian Health Practitioner Regulation Agency (AHPRA); the NSW Medical Council; and if appropriate, to equivalent bodies in other states for advice on relevant matters relating to my professional conduct, performance or health.

Preferred address:

Is this? ◯ Home or

◯ Practice - Please include practice name

_____

_____

_____

_____

Preferred email address: _____

Mobile Telephone _____

Current work setting:
◯ Public ◯ Private ◯ General Practice

Type of practice: _____

_____ _____ _____/_____/20_____
Signature Print name in block letters Date