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| 1. **Applicant details** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name: | |  | | | | | | | | | | | | Surname: | |  | | | | | | | | | |  |
| Prescriber number: | | | |  | | | | | AHPRA Registration No: | | | | | | | |  | | | | | | | | |  |
| Practice name: | | |  | | | | | | | | | | | | | | | | | | | | | | |  |
| Address: |  | | | | | | | | | | Suburb: | |  | | | | | | | Postcode: | |  | | | |  |
| Telephone: | |  | | | | | Fax: |  | | | | | | | Practice email: | | |  | | | | | | | |  |
| Postal address (if different to practice address): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: |  | | | | | | | | | Suburb: | |  | | | | | | | Postcode: | |  | | | |  | |
| Do you have any outstanding actions against you in relation to prescribing? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes, please provide details: | | | | | |  | | | | | | | | | | | | | | | | | No | | | |
| Are you subject to Medical Board of Australia supervision conditions? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes, please indicate level: | | | | |  | | | | | | | | | | | | | | | | | | | No | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| 1. **Other practitioner details** | | | | |
| Are other practitioners at this practice authorised CPOP prescribers? | | Yes | No | |
| If yes, please provide details: |  | | |  |
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| 1. **Practice details: Compliant Schedule 8 drug safe (Depot buprenorphine formulations only)** | | |
| Does the practice have a compliant Schedule 8 drug safe installed? | Yes | No |
| Refer to <https://ww2.health.wa.gov.au/Articles/S_T/Storage-of-Schedule-8-medicines> | | |
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| 1. **Prescriber declaration** | | | | |
| I agree to comply with the requirements of the Medicines and Poisons Regulations 2016, *Schedule 8 Medicines Prescribing Code* and the *Western Australian Clinical Policies and Procedures for the Use of Methadone and Buprenorphine in the Treatment of Opioid Dependence* and any conditions imposed by the Chief Executive Officer of the Department of Health. | | | | |
| Signature: |  | Date: |  |  |
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| **Office Use Only: Community Pharmacotherapy Program** | | | | | |
| The above practitioner has satisfactorily completed CPOP training and prescriber assessment delivered by the Community Pharmacotherapy Program and is recommended for authorisation as a prescriber as follows *(tick all that apply)* | | | | | |
| Buprenorphine formulations | | Co-Prescriber | | | |
| Methadone (addition) | |  | | | |
| Director of Clinical Services |  | | Date: |  |  |
|  | | | | | |