POISONS AND DANGEROUS DRUGS ACT

APPLICATION TO POSSESS POISONS IN A DHF EMERGENCY MEDICINES KIT

TO: Chief Poisons Inspector
Department of Health and Families
PO Box 40596
CASUARINA NT 0811

Phone: 8922 7341
Fax: 8922 7200

I hereby apply under Section 42 of the *Poisons and Dangerous Drugs Act* to possess poisons in a medical kit. In support of my application, I provide the following details.

PLEASE NOTE: If you are **requesting injectables** you must provide proof of one of the following:

a) Medical Kit Training Information Day attendance – recommended every 2 years; NB: 3 year expiry
b) have an OCCUPATIONAL 1st Aid Certificate
c) be a REGISTERED Nurse

All basic (nil injections) kit holders **must** attend the Medical Kit Training Information Day or equivalent within 12 months of their application being approved.

PART A: DETAILS OF PERSON TO BE IN CHARGE OF MEDICAL KIT

1. Name (in full):...Date of Birth: ..../......./.....
2. Occupation:...Professional Qualifications:...................................
3. Residential address:...
4. Postal address:..
5. Phone number:..................................Facsimile Number:..
   Email address: ....
6. Give details of drug related criminal offences (if any)..
7. Can this applicant read and write in the English language?:...
8. Signature of person named at “1” above: ....

PART B: DETAILS OF THE MEDICAL KIT

9. State full address where Medical Kit will be stored:..
10. Postal address:..
11. Phone number:..................................Facsimile Number:..
12. State name/address of nearest Medical or Health Centre..
13. State distance from nearest Medical or Health Centre..
14. How many people will the Kit cover?...........................Adults..............................Children
15. I declare that the information provided above and in the attachments hereto is true and correct.

SIGNATURE OF APPLICANT:...DATE:...............................

PART C: DETAILS OF DEPUTY/DEPUTIES TO BE IN CHARGE OF MEDICAL KIT

16. Name (in full):……………………………………Date of Birth: ……/……/……
17. Occupation:……………………………Professional Qualifications:……………………………
18. Residential address:……………………………………………………………
19. Postal address:……………………………………………………………
20. Phone number:……………………………Facsimile Number:……………………………
21. Give details of drug related criminal offences (if any)……………………………
22. Can this applicant read and write in the English language?:……………………………
23. Signature of person named at "16" above: ……………………………………

PART D: DETAILS OF DEPUTY/DEPUTIES TO BE IN CHARGE OF MEDICAL KIT

24. Name (in full):……………………………………Date of Birth: ……/……/……
25. Occupation:……………………………Professional Qualifications:……………………………
26. Residential address:……………………………………………………………
27. Postal address:……………………………………………………………
28. Phone number:……………………………Facsimile Number:……………………………
29. Give details of drug related criminal offences (if any)……………………………
30. Can this applicant read and write in the English language?……………………………
31. Signature of person named at "24" above: ……………………………………

For Department of Health and Families Rural Medical Administrator or Rural Medical Practitioner use only

BASIC (nil injections) **or** **ALL** (including injections)

Comments (if any):