

**POISONS AND DANGEROUS DRUGS ACT**

**APPLICATION TO POSSESS POISONS  
IN A MEDICAL 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.

**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 DEPUTY/DEPUTIES TO BE IN CHARGE OF MEDICAL KIT<sup>##</sup>**

9. Name (in full): .....Date of Birth:...../...../.....
10. Occupation: ..... Professional qualifications \*\* .....
11. Residential address: .....
12. Postal address: .....
13. Phone number: ..... Facsimile Number: .....
14. Give details of drug related criminal offences (if any).....
15. Can this applicant read and write in the English language?: .....
16. Signature of person named at "9" above: .....

\*\* If the applicant is a nurse, paramedic, safety officer etc, please attach copies of relevant professional qualifications and/or current Certificate to Practice.

<sup>##</sup> If you consider that more than one deputy should be authorised, please attach a paper showing (for each person) the details of items 9 to 16 above. Each deputy named must add his/her signature.

**PART C: DETAILS OF THE MEDICAL KIT**

17. Name of business or employer (eg Government Department): .....
- .....
18. Nature of business activities: .....
19. State full address where Medical Kit will be stored: .....
- .....
20. State name/address of nearest Medical or Health Centre: .....
- .....
21. Phone number:.....Facsimile Number:.....
22. State distance from nearest Medical or Health Centre: .....
23. How many people will the Kit cover?: ..... Adults: .....Children.....
24. State names and qualifications of all staff (other than those previously named under Part A or B who will have access to the poisons in the medical kit. (Attach list if space insufficient).
- .....
- .....
- .....
25. Standard medical kits are listed below, please indicate type for which authorisation is required:
- DHF "Health Centre Drug Imprest Kit" (for remote Health Centres)
- DHF "Recommended Medical Kit for Fishing Vessel"
- Salbutamol (eg Asthma Emergency First Aid Kit)
- Royal Flying Doctor Service Medical Kit
- Australian Maritime Safety Authority (Marine Orders Part 10, Scale.....)
- Australian Yachting Federation Medical Kit
- Other (state type): .....
26. Please attach
- a) your imprest list with all drug items and their strengths and quantities
- b) your PROTOCOLS
- c) letter from health professional endorsing drugs to be held in kit
- d) relevant practising certificates
27. I declare that the information provided above and in the attachments here to is true and correct.

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