



Private hospital new licence application

Instructions

The following application package relates to the application for a licence under the *Private Hospital and Health Services Act 1927*.

The application form has 6 sections:

- Section A** Demographic information
- Section B** Proposed functionality of facility
- Section C** Assessment of the licence applicant
- Section D** Assessment of the premises
- Section E** Assessment of the arrangements for management, staffing and equipment
- Section F** Accreditation

Each section must be completed. To ensure validation by licence applicant, signatures are required throughout the application.

The following documents will assist you to complete your application:

1. Licensing Standards for Assessing the Suitability of a Licence Applicant or a Licence Holder
2. Private Hospital or Day Hospital Class A Guidelines – as relevant
3. Licensing Standards for the Arrangements for Management, Staffing and Equipment
4. WA Health Facility Guidelines for Engineering Services.

A non-refundable prescribed fee will be issued upon receipt of the application.

These fees are as scheduled:

- | | |
|--|-------------|
| • Fewer than 25 persons to be accommodated | \$ 8,960.00 |
| • 25 – 100 persons to be accommodated | \$10,110.00 |
| • 101 – 200 persons to be accommodated | \$13,110.00 |
| • 201 – 500 persons to be accommodated | \$16,110.00 |
| • More than 500 persons to be accommodated | \$19,110.00 |

On completion of the application package, please email LARULicensing@health.wa.gov.au, notifying them and an invitation will be sent to you to join MyFT (a document sharing site). A set of instructions will also be sent to you to show you how to upload/download application documents and return them to the LARU electronically.

Additional information can be viewed on the Licensing and Accreditation Regulatory Unit website at http://www.health.wa.gov.au/private_licensing



Section A: Demographic information

Licensing applicant/company/individual/firm/partnership/statutory body

Name of licence applicant:

Mobile:

Email:

Anticipated date you require your licence: / /

Please note: A minimum of 30 days is required to process your licence application

Facility details

Name of facility:

Facility address:

Suburb:

State:

Post code:

Phone:

Email:

PO box no:

Suburb:

Post code:

ABN:

ACN:

Chief Executive Officer/General Manager (however titled)

Salutation: Mr Mrs Ms Miss Dr Prof

First name:

Last name:

Position title:

Address:

Suburb:

State:

Post code:

Phone:

Mobile:

Email:

Section A: Demographic information

Director of Nursing (however titled)

Salutation: Mr Mrs Ms Miss Dr Prof

First name:

Last name:

Phone:

Mobile:

Email:

Medical Director (however titled)

Salutation: Mr Mrs Ms Miss Dr Prof

First name:

Last name:

Phone:

Mobile:

Email:

Section A: Clinical specialties private hospitals

When completing this form, only tick specialties, surgeries and procedures that are provided by the licensed hospital. DO NOT include services that are provided by external services providers E.g., Radiology, Sleep Studies, Pathology.

Medicine * only tick if you are funded for in -patient medical beds and or practice medicine for these specialties

Addiction	Gynaecology	Obstetrics and gynae	Reproductive/infertility
Anaesthesiology	Haematology	Oncology	Respiratory/sleep
Cardiology	Hepatology	Ophthalmology	Rheumatology
Dermatology	Immunology/allergy	Paediatric	Sleep studies
Emergency	Infectious diseases	Pain management	Thoracic
Endocrinology	Intensive care	Palliative	Urology
Endovascular	Nephrology	Psychiatry	Vascular
General	Nuclear medicine	Radiology - diagnostic	
Gastroenterology	Neonatal/perinatal	Radiology - oncology	
Gerontology	Neurology	Rehabilitation	

Surgeries * only tick if you conduct these surgeries

Bariatric	Gastrointestinal	Neuro	Plastic/reconstructive
Cardio-thoracic	Gynaecological	Obstetrics	Podiatric
Colorectal	Hand	Oculo - plastics	Renal
Cosmetic	Hepatic	Oral maxilla/facial	Robotic
Endovascular	Laser/lasik	Otolaryngology	Spinal/thoracic
Ear nose throat	Minor orthopaedics	Ophthalmic	Urological
General	Major orthopaedics	Paediatric	Vascular

Procedures * only tick if you offer these procedures

Assisted Reproductive	Dental	Haemodialysis	Peritoneal dialysis
Cardiac interventional	ECT	Gastroscopy	rTMS
Capsule endoscopy	Endoscopy	Gynaecological	
Colonoscopy	Egg collections	Pain management related	

Section A: Clinical specialties private hospitals

Other * please add if not captured by previous categories stated

I _____ in position of _____
confirm these services are provided at this facility.

Name:

Signature:

Date: / /

Please note: All items ticked will be reflected on your licence

Section A: Proposed number of patients and declaration

These figures will be used to determine the maximum number of in-patient beds and the maximum number of patients that can be treated at any one time

Please refer to the 'Definition of a bed' [Policy](#) located on the Licensing and Accreditation Regulatory Unit website when calculating these numbers.

	Speciality/area	Number of beds
Inpatient beds	Medical	
	Maternity/obstetrics	
	Surgical (include 23hr day hospital beds)	
	Paediatrics	
	Nursery cots – Level 2 or greater	
	Restorative/rehabilitation/aged care	
	Intensive care unit	
	Coronary care unit	
	High dependency unit	
	Palliative	
	Mental health excluding authorised	
	Authorised mental health (defined by the <i>Mental Health Act 2014</i>)	
	Other	
Total number of beds	X=	

Section A: Proposed number of patients and declaration

	Speciality/area	Number of beds
Delivery suite	Delivery beds	
Day Procedure	Holding bay trolleys/chairs	
	Recovery bay trolleys/beds	
	Recovery chairs (if applicable)	
	Discharge chairs (if applicable)	
In-patient day chemotherapy chairs	Oncology chairs	
In and outpatient renal dialysis chairs	Dialysis chairs	
In-patient mental health day therapy chairs	Maximum number of patients able to attend therapy at a time	
Emergency department (ED)	ED resuscitation trolleys	
	ED treatment trolleys	
	ED isolation trolleys	
	ED plaster trolley/chair (as applicable)	
	ED observation bay/trolley (if applicable)	
Total number of patients treated		Y
Maximum number of patients to be treated at any one time		X + Y=

Declaration – Licence holder/authorised delegate

I declare that the above information regarding maximum beds and numbers of patients treated at any one time is correct.

Name:

Position:

Signature:

Date : / /



Section B: Proposed functionality of facility

In assessing an application for a private hospital licence, the Director General of Health has a duty to approve the licence applicant, the premises and the arrangements for management, staffing and equipment. The 'Proposed functionality of facility' provides vital information that is utilised by the Director General when determining whether to grant an applicant a licence.

The Proposed functionality of facility should be no more than 3 pages and it should articulate the functionality of the organisation. The intention is not to duplicate matters that are submitted in your licence application but to provide a snapshot of the functions that will be carried out within the premises to be approved.

Please attach your Proposed functionality of facility which briefly outlines the following points:

The application form has 5 sections:

General information

- Name of licence applicant/owner/company/firm/partnership/statutory body
- Name of facility
- Address of facility
- Primary function of the facility – the normal or intended activities of the facility
- The reason/rationale for the service
- Service philosophy/scope of the service/proposed level of service
- Model of care provision
- Days and hours of operation
- Funding mechanism: for profit/not for profit/other

Clinical services

- Medical and surgical specialties, procedures, treatments, psychiatric and psychological services to be provided
- Anticipated through-put e.g. number of beds, maximum number of patients treated at any one time, intended through-put for each specialty, area.
- Approximate average number of inpatients per day.
- Referral mechanisms. e.g. specialist
- Intended age range of patients where relevant:
 - Adults age 18 years and over
 - Paediatrics
 - Neonates
 - Infants/toddlers
 - Children
 - Teens

Section B: Proposed functionality of facility

Building

- Building Classification (BCA)
- Age of facility
- Anticipated life of facility
- Provide electronic copies of floor plans that are appropriately labelled
- Advise if there will be phased building works, planned time frames, how services will be maintained (if required), temporary accommodation requirements and how patients will be managed during building works

Staffing

- Intended staff mix and staff to patient ratio per area/specialty
- Support staff

Support services

- Asset management
- Ambulance access
- Car parking
- Equipment and infrastructure
- Facility maintenance
- Food services
- Infection control
- Information technology/communications
- Fire and security
- Laundry and linen
- Sterile supplies
- Security
- Transport – access to public transport
- Waste management



Section C: Assessment of licence applicant

Part of the assessment of an application for a licence involves a determination that the licence applicant satisfies the requirements. Refer to the Licensing Standards for Assessing the Suitability of a Licence Applicant or a Licence Holder.

The licence applicant is required to provide the following: (please tick if submitted)

Demographic information

Birth certificate/s

- If name has changed since birth certification, legal documentation of change to be provided. (E.g. Certified Deed Poll, marriage certificate etc.)

Copies of:

- The certificate of Statutory Body Number if applicable
- The specific legislation of incorporation
- Any change of identity

Character references: one for each person charged with management responsibility under the relevant legislation

Current (dated within 6 months of application date) National Police Certificate for each person charged with management responsibility under the relevant legislation

Licence applicant's character and reputation declaration

Primary financial institutional financial reference

Independent accountant financial certification

Licence applicant's financial declaration

Copies of certificates of currency for the following classes of risk, including the amount of insurance cover:

- Professional indemnity
- Medical malpractice
- Building or industrial special risks
- Public liability
- Workers compensation, or if a self-insurer.

Details of the operational management team, that being:

- Positions that include General Manager, Chief Executive Officer, Director of Nursing and Medical Director
- Current curriculum vitae

Operational management teams competency declarations

Written information of any outstanding criminal charges, convictions (other than spent convictions) made against them or anyone involved in the management of the facility.

Written documentation (details and outcome) of any breaches of the *Corporations Act 2001* (or any other Act administered by the Australian Securities Investments Commission) or the *Trade Practices Act*.

Written documentation (details and outcome) of any referrals or complaints by any professional registration board or association

Written information (details and outcome) on any person involved in the management or ownership of the facility being declared bankrupt

Section C: Assessment of licence applicant

Demographic information

Name of company/individual/firm/partnership/statutory/corporate body:

ACN:

ABN:

Registered business name:

Business address:

Suburb:

Post code:

State:

PO box:

Post code:

State:

Phone:

Mobile:

Email:

Licence holder

Salutation: Mr Mrs Ms Miss Dr Prof

First name:

Last name:

Position title:

Address:

Suburb:

Post code:

State:

Phone:

Mobile:

Email:

Section C: Assessment of licence applicant

Names of board members/company directors/other (if applicable)

Note: Please provide current National Police Certification for each person

Names		Date commenced	Term of office
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Section C: Assessment of licence applicant

Licence applicant financial declaration

Explanatory note: The person signing this declaration must be either the licence applicant or a person authorised by the licence applicant.

I declare that

(Name of the company/individual/firm/partnership/statutory body)

1. has sufficient material and financial resources available to comply with the requirements of the *Private Hospitals and Health Services Act 1927 (WA)*
2. I am duly authorised to make this declaration
3. the information contained in this application is true and correct. I understand that if it is subsequently established that any information provided is not true and correct, any licence issued may be suspended or revoked.

Name:

Position:

Signature:

Date: / /

Section C: Assessment of licence applicant

Independent accountant – financial certification

Explanatory note: The person signing the declaration must be a Certified Practising Accountant (CPA), and be a member of the CPA Australia and independent to Licence Applicant.

I, _____
Name and qualifications of accountant

of _____
Name and address of firm

having reviewed the financial records of _____
Name of company/individual/firm/partnership/statutory body

declare that _____
Name of company/individual/firm/partnership/statutory body

1. has sufficient material and financial resources available to comply with the requirements of the *Private Hospitals and Health Services Act 1927 (WA)*
2. has, and will continue to have, the financial capacity to operate the facility and to pay its debts as and when they fall due.

Name: _____ Position: _____

Signature: _____ Date: ____ / ____ / ____

CPA Australia membership number: _____

Phone: _____ Mobile: _____

Email: _____

Section C: Assessment of licence applicant

Primary financial institution – financial reference

Please provide the following information on your company or financial institution letterhead.

I, (Name) _____

in my capacity as (Title) _____

for (Name of primary financial institution) _____

located at (Address) _____

1. Has maintained a business account at the above-mentioned financial institution since: enter a date.
2. During this time, they have conducted their accounts in a satisfactory manner.
3. In accordance with the terms and conditions of the accounts.

Name: _____ Position: _____

Signature: _____ Date ____ / ____ / ____

Section C: Assessment of licence applicant

Independent accountant financial certification

The person completing and signing this declaration must:

Be a fully qualified accountant and hold full (not associate) membership of one of the following:

- a. CPA Australia
- b. Chartered Accountants Australia and New Zealand (CAANZ)
- c. Institute of Public Accountants (IPA)
- d. Hold a public practice certificate (PPC)
- e. Independent to licence applicant

Please sign the declarations below attesting to (i) and (ii).

I, _____
Name and qualifications of accountant

of _____
Name of company/individual/ firm/partnership/statutory body

Having reviewed the financial records of _____
Name of company/individual/ firm/partnership/statutory body

Declare that _____
Name of company/individual/ firm/partnership/statutory body

1. has sufficient material and financial resources available to comply with the requirements of the *Private Hospitals and Health Services Act 1927 (WA)*
2. has, and will continue to have, the financial capacity to operate the facility and to pay its debts as and when they are due.

Name: _____ Position: _____

Signature: _____ Date: / /

Phone: _____ Mobile: _____

Email: _____

Section C: Assessment of licence applicant

Declaration:

I declare that:

a. Hold current and full membership of

(enter one of CPA, CAANZ or IPA).

b. Hold a current public practice certificate (PPC).

Name:

Position:

Signature:

Date: / /

Section C: Assessment of licence applicant

Operational management team competency declaration

Explanatory note: A declaration must be completed for each of the following – Chief Executive Officer, Director of Nursing and Medical Director (however titled).

I,

Name

of

Name of the Facility

in my capacity as the

Position Title

Declare that:

- I have no charges or convictions of a criminal offence
- I have no referrals or complaints by any professional registration board or association
- I understand the duties and obligations to conduct the facility.

Name:

Signature:

Date: / /

Licence Applicant Name:

Signature:

Date: / /

Section C: Assessment of licence applicant

Document check list

Once you have completed the application, please notify the LARU via LARULicensing@health.gov.wa.au

You will be sent an invite to join MyFT (document transfer platform). A set of instructions will also be provided to assist you with the upload and download of documents electronically.

Please tick if submitted:

Functional brief

Birth certificate

Character references

National Police Clearances

Financial declarations

Insurances

Corporate organisational and committee charts

Additional information



Section D: Ownership of premises

Part of the assessment of an application for a licence involves a determination that the premises are approved. Refer to the Building Guidelines.

You are required to advise on the following:

1. The licence applicant is owner of the premises
(if yes, sign declaration for ownership)
2. The licence applicant is purchasing the premises
(if yes, sign declaration from an existing Licence Holder)
3. Licence applicant is leasing the premises
(if yes, sign declaration for lease of premises)

Ownership of premises declaration

Explanatory note: The person signing this declaration must be either the licence applicant or a person authorised by the licence applicant.

I, _____ (Insert name)

of _____ (Insert address)

declare that:

1. the licence applicant has ownership of the premises of the licensed private health facility.
2. the information contained in this declaration is true and correct. I understand that if it is subsequently established that any information provided is not true and correct, any licence issued may be suspended or revoked.
3. I am duly authorised to make this declaration.

Name

Position

Signature

Date: / /

Section D: Ownership of premises

Leasehold of premises declaration

Explanatory note: The person signing this declaration must be either the licence applicant or a person authorised by the licence applicant.

I, _____ Insert name

of _____ Insert address

In the position of _____ Insert position

Declare that:

The owner of the building is _____ Insert name

of _____ Insert address

Mobile:

Email:

- Where the licence applicant has entered into, or plans to enter into, a leasing arrangement for both the building and the land or either the building or the land, the terms of the leasing arrangement ensures, or will ensure, that the licence applicant will comply with all the provisions of the *Private Hospitals and Health Services Act 1927*, including the possession of a lease that allows all necessary building works to be undertaken in compliance with the Private Hospital Guidelines, associated regulations, codes and standards, as amended from time to time. Where the terms of the lease conflict with the requirements of the *Private Hospitals and Health Services Act 1927*, the *Private Hospitals and Health Services Act 1927* will prevail.
- The information contained in this declaration is true and correct. I understand that if it is subsequently established that any information provided is not true and correct, any licence issued may be suspended or revoked
- I am duly authorised to make this declaration.

Name:

Position:

Signature:

Date: / /

Section D: Ownership of premises

Assessment of the premises

What is your proposed date for occupation? / /

Explanatory note: The proposed date for occupation, is the date the first patient is admitted. Therefore, the date you require the licence to be issued.

Advise on the status of your building:

1. Currently occupied
2. Ready for occupation
3. Requiring renovation prior to occupation
4. To be built prior to occupation
5. Currently being built for occupation

If you have ticked 1 or 2, the following is required:

- a) Plans of the facility
- b) A schematic fire and emergency evacuation plan

If you have ticked 3, 4 or 5, the following is required:

The licence applicant is required to contact the Licensing and Accreditation Regulatory Unit (LARU) (6373 2347) to arrange a meeting with the LARU manager/building team to discuss the building approval process.

Once your application is completed, please notify the Licensing Team via email LARULicensing@health.wa.gov.au
A link to MyFT will then be sent to you along with instructions on how to upload your application documents electronically.

Please tick if submitted:

Current floor plans

Fire evacuation plan



Section E: Assessment of arrangements for management, staffing and equipment

Part of the assessment of an application for a licence involves a determination that the arrangements for management, equipment and staffing are satisfactory. Refer to the Licensing standards for the arrangements for management, staffing and equipment.

You are required to provide the following:

1. Two organisational charts

- Corporate organisational chart showing the relationships between the company/licence holder and the facility.
- Facility organisational chart.

2. Facility committee structure:

Provide a diagrammatic committee structure – this must include:

- Medical Advisory Committee, Credentialing Committee, Occupational Health and Safety, Quality, and Infection Control.
- Demonstrate the lines of communication and the reporting mechanism.

3. Staffing

- Document the number of staff and identify the type of staff (clinical and non-clinical) in each area and speciality (including non-clinical areas and procedural/theatre areas).
- For clinical staff include staff to patient ratio.

Please note: The information requested is the minimum requirement to enable an assessment to take place. The risk remains with the licence applicant if the information provided is in any way deficient.

Once application is completed, please notify the Licensing Team via LARULicensing@health.wa.gov.au

A link to MyFT will then be sent to you along with instructions on how to upload your application documents electronically.

Please tick if submitted:

Corporate organisational chart

Facility organisational chart

Facility committee chart

Staffing



Section F: Accreditation

All public and private hospitals including Class A day hospitals as defined in the *Private Hospitals and Health Services Act 1927* and associated licensing standards are required to achieve and maintain accreditation to the National Safety and Quality Health Service Standards. The Licensing and Accreditation Regulatory Unit (LARU) is responsible in ensuring that these class of private hospitals maintain accreditation and reports in accordance with the LARU requirements.

The form applies to private hospitals.

The Accreditation registration form has 2 parts:

Part 1 Demographic information

Part 2 Accreditation information
Declaration of licence holder/authorised person

Each section must be completed. To ensure validation, the form requires the signature of the licence holder or authorised person.

Once the application is completed, please notify the Licensing Team via LARULicensing@health.wa.gov.au. An invitation to join MyFT will be emailed to you along with a set of instructions on how to upload/download application documents electronically.

If you require any clarification about the Accreditation Registration Form, please contact the Licensing and Accreditation Regulatory Unit (LARU) on 6373 2347 or via LARUAccreditation@health.wa.gov.au

Section F: Accreditation

Part 1: Demographic information

Main contact person for accreditation

Name:

Position:

Mobile:

Email:

Section F: Accreditation

Part 2: Accreditation information

Accrediting agency:

Phone:

Email:

Contract start date: / /

Expiry date: / /

Accreditation status:

Accredited 2nd Edition of the NSQHS Standards

Accreditation pending

Not yet accredited to the 2nd Edition of the NSQHS Standards

Accreditation certification start date: / /

Expiry date: / /

Accreditation programme

Explanatory note: Health Service Organisations are now assessed once every 3 years, unless you meet the criteria for a repeat assessment. Certification is only issued for a 3 month period. Exceptions to this requirement is only considered on a case by case basis.

My last organisation wide assessment was on the: / /

My current certification to the 2nd Edition NSQHS Standards expires: / /

Licence holder/authorised delegate confirmation of information

I declare as the licence holder or authorised delegate that:

1. The information contained in Parts 1 and 2 of the registration form is true and correct
2. I am duly authorised to make this declaration

Name:

Position:

Signature:

Date: / /

This document can be made available in alternative formats. on request for a person with disability.

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