



## Application to register as an immunisation provider

### Important information

Complete this form if you are an individual or organisation wanting to register as an immunisation provider and obtain a registration number for the purposes of sending immunisation data to the Australian Childhood Immunisation Register (ACIR).

If you are a General Practitioner with a registered Medicare provider number, you do not need to complete this form. You can use your Medicare provider number to submit data to ACIR.

### Individual

An individual applicant is a person not operating as an organisation, who provides immunisation services.

### Organisation

An organisation applicant is a body responsible for providing immunisation services (e.g. immunising council, hospital).

### Assistance

If you need assistance completing this form or need information about ACIR call **1800 653 809** (call charges may apply) or go to [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) > **For health professionals > Other programs > Australian Childhood Immunisation Register**

### Lodgement

Send the completed application to your state/territory health department for approval.

Once the state/territory approval section has been completed send to:

**Medicare Australia**  
**GPO Box M933**  
**Perth WA 6843**

If you are a General Practice provider type, state/territory health department approval is not required. Send the completed application directly to Medicare Australia at the above address.

Print in **BLOCK LETTERS**

Tick where applicable

### Applicant's details

**1** Are you applying as an:

Individual  *Go to next question*

Organisation  *Go to 7*

#### Individual

**2** Dr  Mr  Mrs  Miss  Ms  Other

Family name

First given name

**3** Date of birth

 /  / 

**4** Address

  


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 Postcode

**5** Postal address (if different from above)

  


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 Postcode

**6** Work phone number

 ( ) *Go to 12*

#### Organisation

**7** Organisation name

**8** Address

  


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 Postcode

**9** Postal address (if different from above)

  


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 Postcode

**10** Contact person

**11** Work phone number

 ( ) *Go to 12*

## Provider type

**12** From the list below, please tick one box only which best describes your provider type.

Aboriginal health service

– Organisation that provides health services/programs to Indigenous people (fee-for-service)

Aboriginal health worker

– Individual that provides health services/programs to Indigenous people (grant-based)

Community Health Centre

– Public or registered non-profit, community-governed health organisation

Council

– Local government organisation that runs immunisation clinics

Division of General Practice

– Organisation that supports and represents GPs in the local region

Flying doctor service

– Organisation that provides an aero-medical service

General Practice

– A group of two or more GPs wanting to submit ACIR data under one practice number and receive all ACIR payments into one nominated bank account

Private hospital

– Privately funded hospital that requires payment for medical services by patients/insurers

Public Health Unit

– Organisation funded by local government that provides public health services

Public hospital

– Government funded hospital that provides free health care

Other (please specify)

## Bank account details

All payments relating to ACIR data submitted under the new registration number will be made into the account below.

**13** Name of bank, building society or credit union

Branch where the account is held

Branch number (BSB)

 – 

Account number

Account name

## Declaration

**14** I declare that:

- the information on this form is correct.

Applicant's full name

Applicant's signature

Date

## State/territory health department approval

This section is to be completed by the state or territory health department. **If the applicant is a General Practice provider type, approval by the state or territory health department is not required.**

**15** I declare that:

- I recognise the applicant as an immunisation provider for the purposes of the ACIR
- I endorse the registration of the applicant on the ACIR.

Authorised representative's full name

Signature or affixed stamp

**16** Date registration to start

**17** Work phone number

Fax number

## Privacy note

The information provided on this form will be used by the Australian Childhood Immunisation Register to identify you as a recognised immunisation provider. The collection of this information is authorised by the *Health Insurance Act 1973*. This information will be disclosed to the relevant banking institutions in order to facilitate payments of claims and will not be disclosed to any other third party unless authorised or required by law.

## Office use only

ACIR registration number

Operator number

Date of issue