

# Practice Nurse Incentive Program Practice Ownership Details and Declaration

## Important information

Complete this form if you are applying for the Practice Nurse Incentive Program (PNIP) using the PNIP Online. This form will be used to support the information provided in the practice ownership details section of your online application.

Signatures of all individuals, partners, associates and/or authorised representatives who are owners of the practice must be provided.

## Assistance

For more information about the PNIP go to [medicareaustralia.gov.au/pnip](http://medicareaustralia.gov.au/pnip) or email [pnip@humanservices.gov.au](mailto:pnip@humanservices.gov.au). If you need assistance completing this form call the PNIP on **1800 222 032** (call charges apply) between 8.30 am and 5.00 pm, Monday to Friday, Australian Central Standard Time.

## Lodgement

Send the completed form to:

**Practice Nurse Incentive Program**  
**GPO Box 2572**  
**ADELAIDE SA 5001**

or fax to: **1300 587 696**

Print in **BLOCK LETTERS**

Tick where applicable

## Practice details

### 1 Application number

### 2 Practice name

### 3 Practice address

  

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Postcode

### 4 Practice contact number

## Practice ownership details

### 5 Indicate the type of practice ownership arrangement that applies, and complete the declaration below:

#### Individual proprietor

Application to be completed by the proprietor

#### Partnership

Application to be completed by the partners of the practice  
Obtain all partners signatures

#### Associateship

Application to be completed by all associates who are owners of the practice

Do not include the signatures of practice associates who are not owners of the practice

#### Body corporate

Application to be completed by at least two authorised representatives of the corporation (eg: company director and company secretary)

#### State or Territory Government or other public body

Application to be completed by an authorised representative of the practice



**Individual/Partner/Associate/Authorised representative four**

Full name
<input type="text"/>
Position held
<input type="text"/>
RA number (if applicable)
<input type="text"/>
Signature
<input type="text"/>
Date
<input type="text"/>

**Witness**

Full name
<input type="text"/>
Postal address
<input type="text"/>
<input type="text"/>
<input type="text"/>
Postcode
<input type="text"/>
Witness's signature
<input type="text"/>
Date
<input type="text"/>

**Privacy note**

The information provided on this form will be used to assess the practice's eligibility to receive payments under the Practice Nurse Incentive Program. The collection of this information is authorised by the *Human Services (Medicare) Act 1973*. This information may be disclosed to the Department of Health and Ageing or as authorised or required by law.