Authority for authorised pharmacist(s) to sign claim forms

Note: All approved pharmacists should complete this form.

I/We (name/s of approved pharmacist/s)

1. Mr/ Mrs/ Ms
2. Mr/ Mrs/ Ms
3. Mr/ Mrs/ Ms
4. Mr/ Mrs/ Ms

I hereby authorise the following pharmacist(s), whose specimen signature(s) appear below, to sign pharmaceutical benefits claim forms on my/our behalf and to endorse pharmaceutical benefits prescriptions on my/our behalf at the approved premises situated at:

Approval no.

Name(s) of authorised pharmacist(s) (Please print)	**Signature(s)**	**State/Territory Registration No.**

Please: ☐ cancel previous application(s)

☐ add to previous application(s)

Signature of approved pharmacist(s)	**Date**	**Signature of approved pharmacist(s)**	**Date**
1.	/ /	3.	/ /
2.	/ /	4.	/ /

Please note: The information provided by you on this form will be used to validate the identity of authorised pharmacist(s) signing claim forms on behalf of the approved pharmacist(s).

Please return to: **Approvals Clerk**
PBS Processing
Medicare Australia
GPO Box 9826
In your capital city

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