Application to Transfer the Registration of a Health Premises

Public Health and Wellbeing Act 2008

Warrnambool City Council
☎ (03) 5559 4800
www.warrnambool.vic.gov.au

Questions marked with an asterisk (*) are mandatory and must be completed.

CURRENT Proprietor Details

I/We, the undersigned proprietor/s hereby apply to transfer the registration under the provision of the Public Health and Wellbeing Act for the premises described hereunder:

Proprietor ***(If the proprietor is a partnership rather than sole ownership, both names should be listed. If the proprietor is a company or an organisation, the company name should be listed).***

Title * | Surname * | Given Name(s)*

Proprietor 2 (if applicable)

Title * | Surname * | Given Name(s)*

Company Name (if applicable)

Company ABN | Company ACN

Address

Street address / postal address *

Suburb / Town * | State * | Postcode *

Please provide at least one phone number and include the area code *

Business phone | Home phone | Business fax | Mobile

Email

PROPOSED NEW Proprietor Details

Is this business to be registered as a company or an individual(s) ☐ Company ☐ Individual (s)

Title * | Surname * | Given Name(s)*

Proprietor 2 (if applicable)

Title * | Surname * | Given Name(s)*

Company Name (if applicable)

Company ABN | Company ACN

Address

Street address / postal address *

Suburb / Town * | State * | Postcode *

Please provide at least one phone number and include the area code *

Business phone | Home phone | Business fax | Mobile

Email

Premises Details

Trading name of premises *

Premises Address

Street address / postal address *

Suburb / Town * | State * | Postcode *

Contact Person at Premises (if different from proprietor)

Title * | Surname * | Given Name(s)*

Please provide at least one phone number and include the area code *

Business phone | Home phone | Business fax | Mobile

Email

Health Premises Details

Please choose the business activity that your business conducts * *Please select all those that apply*

☐ Beauty therapy ☐ Hairdressing ☐ Colonic irrigation
☐ Skin penetration ☐ Tattooing ☐ Other

Other *

Is the business a mobile health premises? * ☐ Yes ☐ No

Note: Mobile personal care and body art business that conduct skin penetration are not permitted. If you are a mobile hairdresser or a mobile beauty therapist, please register your primary place of business.

Description how the premises will be / is used for * *e.g. body piercing and facials*

A copy of the floor plan is: * ☐ Attached herewith ☐ Previously lodged with Council

Transfer Payment Details

$75.00

Lodgement

Return with Payment to:

Environmental Health
Warrnambool City Council
PO Box 198
Warrnambool VIC 3280

Telephone (03) 5559 4800
Fax (03) 5559 4900
Website: Warrnambool.vic.gov.au

Declaration

I understand and acknowledge that:
- The information provided in this application is true and complete to the best of my knowledge
- This application forms a legal document and penalties exist for providing false or misleading information
- I am over 18 years at the time of completing this application

If the business is owned by a sole treader or partnership, the proprietor(s) must sign and print name(s)

If the business is owned by a company or association – the applicant on behalf of that body must sign and print their name.

CURRENT Proprietor

Signature	Signature
Print Name	Print Name
Date	Date

PROPOSED NEW Proprietor

Signature	Signature
Print Name	Print Name
Date	Date

Proposed transfer date:

Office Use Only	Receipt Date:	Receipt #	Amount:	CSO Initials:
	Account Number: 230 000-1342-41158			

Warrnambool City Council

Name & Address Register (NAR)

Request for the Creation of a New Record – **NEW PROPRIETOR**

Council is collecting the information on this form so that it may consider your application. The information is only used by Council for this purpose and will not be disclosed unless required by law.

HEALTH UNIT

Please complete all the following details:

Trading Name of Business

……..

Business details:

Telephone: (Business)……(fax)……(mobile)……..

Email address……

Postal Service Address……

Town……State……Postcode……

Business Address (if different to service)……..

Town……State……Postcode……

If applicable:

ABN……..

ACN……

Print Name……..……..Date……..

Signature of applicant……..Date……..

OFFICE USE ONLY
Print Name of Officer Submitting: ..... Date .....

NARO: Print name……Date……

PLEASE SEND NEW DEBTOR NUMBER TO HEALTH UNIT

Civic Centre 25 Liebig Street
Telephone (03) 5559 4800
Websitewww.warrnambool.vic.gov.au
Warrnambool Victoria Australia
Facsimile (03) 55594900
ABN 44 594 264 321
PO Box 198 Warrnambool VIC 3280
AUSDOC DX 28005