Application for Registration

Victorian Assisted Reproductive Treatment Authority

Assisted Reproductive Treatment Act 2008 &
Assisted Reproductive Treatment Regulations 2009

This application provides information to meet the statutory requirements outlined in the *Conditions for Registration*. This application is to be completed utilising these conditions. The conditions can be downloaded from the Authority's website at: www.varta.org.au.

The Authority's registration process comprises the following steps:

1. The Application for Registration forms the basis for the ART provider to review its current practice against Authority conditions and must be forwarded to the Authority with supporting documentation.
2. The registered ART provider must forward copies of RTAC accreditation and the accreditation report following each RTAC site inspection.

Please ensure all attachments are labelled to denote the relevant section of the application

1. Organisational Information

The *Assisted Reproductive Treatment Act 2008* stipulates that an application to become a registered ART provider may be made by a person who holds accreditation by the Reproductive Technology Accreditation Committee (RTAC) of the Fertility Society of Australia (FSA).

Name of ART provider: _____

Address: _____

_____

Phone No: _____ Facsimile: _____

Email: _____ Website: _____

1.1 Please attach a list of all sites to be registered under the auspices of the ART provider and their full contact details (see Appendix 1). Please also include dates of RTAC accreditation and a copy of the accreditation report for each site.

Designated Officer

The registered ART provider must ensure there is a Designated Officer and Acting Designated Officer at all times.

1.2 Name of Designated Officer: _____

Address: _____

Phone No: _____ Facsimile: _____

Email: _____ Mobile: _____

1.3 Acting Designated Officer: _____

Address: _____

Phone No: _____ Facsimile: _____

Email: _____ Mobile: _____

2. Signatures

This application has been completed by the legal person or nominee of the ART provider

Witness Signature: _____

Name: _____

Date: _____

Legal Person or Nominee of ART Provider

Legal Person Signature: _____

Name: _____

Date: _____

Witness Signature: _____

Designated Officer

Designated Officer Signature: _____

Name: _____

Date: _____

Witness Signature: _____

Please return application to:

Victorian Assisted Reproductive Treatment Authority
PO Box 16123
Collins Street West, VIC 8007

Appendix 1 – Site Details

Site 1

Contact Details

Name of site: _____

Address: _____

_____

Phone No: _____ Facsimile: _____

Email: _____ Website: _____

RTAC Accreditation

Please identify the current status of accreditation for this site with RTAC. If approval has been received, please note the date of approval and attach a copy of accreditation and accreditation report. If not approved, please attach a full explanation.

RTAC accredited: ☐ Yes ☐ No

Date: _____

Explanation: _____

Accreditation report attached: ☐ Yes ☐ No

Treatment Procedures

Please indicate procedures supplied by the ART provider at this site:

IVF ☐ GIFT ☐ ICSI ☐ AI ☐ PGD ☐ Gamete Storage ☐ Embryo Storage ☐

Other: _____

Storage Facility

Please indicate whether the following are stored by the ART provider at this site on a permanent or temporary basis (i.e. only while satellite clinic operating):

	Permanent	Temporary
Embryos	☐	☐
Sperm stored for medical/social reasons	☐	☐
Partner's sperm	☐	☐
Donor sperm	☐	☐
Donor eggs	☐	☐
Eggs stored for medical/social reasons	☐	☐
Ovarian tissue	☐	☐

Site 2

Contact Details

Name of site: _____

Address: _____

_____

Phone No: _____ Facsimile: _____

Email: _____ Website: _____

RTAC Accreditation

Please identify the current status of accreditation for this site with RTAC. If approval has been received, please note the date of approval and attach a copy of accreditation and accreditation report. If not approved, please attach a full explanation.

RTAC accredited: ☐ Yes ☐ No

Date: _____

Explanation: _____

Accreditation report attached: ☐ Yes ☐ No

Treatment Procedures

Please indicate procedures supplied by the ART provider at this site:

IVF ☐ GIFT ☐ ICSI ☐ AI ☐ PGD ☐ Gamete Storage ☐ Embryo Storage ☐

Other: _____

Storage Facility

Please indicate whether the following are stored by the ART provider at this site on a permanent or temporary basis (i.e. only while satellite clinic operating):

	Permanent	Temporary
Embryos	☐	☐
Sperm stored for medical/social reasons	☐	☐
Partner's sperm	☐	☐
Donor sperm	☐	☐
Donor eggs	☐	☐
Eggs stored for medical/social reasons	☐	☐
Ovarian tissue	☐	☐

Site 3

Contact Details

Name of site: _____

Address: _____

_____

Phone No: _____ Facsimile: _____

Email: _____ Website: _____

RTAC Accreditation

Please identify the current status of accreditation for this site with RTAC. If approval has been received, please note the date of approval and attach a copy of accreditation and accreditation report. If not approved, please attach a full explanation.

RTAC accredited: ☐ Yes ☐ No

Date: _____

Explanation: _____

Accreditation report attached: ☐ Yes ☐ No

Treatment Procedures

Please indicate procedures supplied by the ART provider at this site:

IVF ☐ GIFT ☐ ICSI ☐ AI ☐ PGD ☐ Gamete Storage ☐ Embryo Storage ☐

Other: _____

Storage Facility

Please indicate whether the following are stored by the ART provider at this site on a permanent or temporary basis (i.e. only while satellite clinic operating):

	Permanent	Temporary
Embryos	☐	☐
Sperm stored for medical/social reasons	☐	☐
Partner's sperm	☐	☐
Donor sperm	☐	☐
Donor eggs	☐	☐
Eggs stored for medical/social reasons	☐	☐
Ovarian tissue	☐	☐

Site 4

Contact Details

Name of site: _____

Address: _____

_____

Phone No: _____ Facsimile: _____

Email: _____ Website: _____

RTAC Accreditation

Please identify the current status of accreditation for this site with RTAC. If approval has been received, please note the date of approval and attach a copy of accreditation and accreditation report. If not approved, please attach a full explanation.

RTAC accredited: ☐ Yes ☐ No

Date: _____

Explanation: _____

Accreditation report attached: ☐ Yes ☐ No

Treatment Procedures

Please indicate procedures supplied by the ART provider at this site:

IVF ☐ GIFT ☐ ICSI ☐ AI ☐ PGD ☐ Gamete Storage ☐ Embryo Storage ☐

Other: _____

Storage Facility

Please indicate whether the following are stored by the ART provider at this site on a permanent or temporary basis (i.e. only while satellite clinic operating):

	Permanent	Temporary
Embryos	☐	☐
Sperm stored for medical/social reasons	☐	☐
Partner's sperm	☐	☐
Donor sperm	☐	☐
Donor eggs	☐	☐
Eggs stored for medical/social reasons	☐	☐
Ovarian tissue	☐	☐

Site 5

Contact Details

Name of site: _____

Address: _____

_____

Phone No: _____ Facsimile: _____

Email: _____ Website: _____

RTAC Accreditation

Please identify the current status of accreditation for this site with RTAC. If approval has been received, please note the date of approval and attach a copy of accreditation and accreditation report. If not approved, please attach a full explanation.

RTAC accredited: ☐ Yes ☐ No

Date: _____

Explanation: _____

Accreditation report attached: ☐ Yes ☐ No

Treatment Procedures

Please indicate procedures supplied by the ART provider at this site:

IVF ☐ GIFT ☐ ICSI ☐ AI ☐ PGD ☐ Gamete Storage ☐ Embryo Storage ☐

Other: _____

Storage Facility

Please indicate whether the following are stored by the ART provider at this site on a permanent or temporary basis (i.e. only while satellite clinic operating):

	Permanent	Temporary
Embryos	☐	☐
Sperm stored for medical/social reasons	☐	☐
Partner's sperm	☐	☐
Donor sperm	☐	☐
Donor eggs	☐	☐
Eggs stored for medical/social reasons	☐	☐
Ovarian tissue	☐	☐

Site 6

Contact Details

Name of site: _____

Address: _____

_____

Phone No: _____ Facsimile: _____

Email: _____ Website: _____

RTAC Accreditation

Please identify the current status of accreditation for this site with RTAC. If approval has been received, please note the date of approval and attach a copy of accreditation and accreditation report. If not approved, please attach a full explanation.

RTAC accredited: ☐ Yes ☐ No

Date: _____

Explanation: _____

Accreditation report attached: ☐ Yes ☐ No

Treatment Procedures

Please indicate procedures supplied by the ART provider at this site:

IVF ☐ GIFT ☐ ICSI ☐ AI ☐ PGD ☐ Gamete Storage ☐ Embryo Storage ☐

Other: _____

Storage Facility

Please indicate whether the following are stored by the ART provider at this site on a permanent or temporary basis (i.e. only while satellite clinic operating):

	Permanent	Temporary
Embryos	☐	☐
Sperm stored for medical/social reasons	☐	☐
Partner's sperm	☐	☐
Donor sperm	☐	☐
Donor eggs	☐	☐
Eggs stored for medical/social reasons	☐	☐
Ovarian tissue	☐	☐

Site 7

Contact Details

Name of site: _____

Address: _____

_____

Phone No: _____ Facsimile: _____

Email: _____ Website: _____

RTAC Accreditation

Please identify the current status of accreditation for this site with RTAC. If approval has been received, please note the date of approval and attach a copy of accreditation and accreditation report. If not approved, please attach a full explanation.

RTAC accredited: ☐ Yes ☐ No

Date: _____

Explanation: _____

Accreditation report attached: ☐ Yes ☐ No

Treatment Procedures

Please indicate procedures supplied by the ART provider at this site:

IVF ☐ GIFT ☐ ICSI ☐ AI ☐ PGD ☐ Gamete Storage ☐ Embryo Storage ☐

Other: _____

Storage Facility

Please indicate whether the following are stored by the ART provider at this site on a permanent or temporary basis (i.e. only while satellite clinic operating):

	Permanent	Temporary
Embryos	☐	☐
Sperm stored for medical/social reasons	☐	☐
Partner's sperm	☐	☐
Donor sperm	☐	☐
Donor eggs	☐	☐
Eggs stored for medical/social reasons	☐	☐
Ovarian tissue	☐	☐

Site 8

Contact Details

Name of site: _____

Address: _____

_____

Phone No: _____ Facsimile: _____

Email: _____ Website: _____

RTAC Accreditation

Please identify the current status of accreditation for this site with RTAC. If approval has been received, please note the date of approval and attach a copy of accreditation and accreditation report. If not approved, please attach a full explanation.

RTAC accredited: ☐ Yes ☐ No

Date: _____

Explanation: _____

Accreditation report attached: ☐ Yes ☐ No

Treatment Procedures

Please indicate procedures supplied by the ART provider at this site:

IVF ☐ GIFT ☐ ICSI ☐ AI ☐ PGD ☐ Gamete Storage ☐ Embryo Storage ☐

Other: _____

Storage Facility

Please indicate whether the following are stored by the ART provider at this site on a permanent or temporary basis (i.e. only while satellite clinic operating):

	Permanent	Temporary
Embryos	☐	☐
Sperm stored for medical/social reasons	☐	☐
Partner's sperm	☐	☐
Donor sperm	☐	☐
Donor eggs	☐	☐
Eggs stored for medical/social reasons	☐	☐
Ovarian tissue	☐	☐

Site 9

Contact Details

Name of site: _____

Address: _____

_____

Phone No: _____ Facsimile: _____

Email: _____ Website: _____

RTAC Accreditation

Please identify the current status of accreditation for this site with RTAC. If approval has been received, please note the date of approval and attach a copy of accreditation and accreditation report. If not approved, please attach a full explanation.

RTAC accredited: ☐ Yes ☐ No

Date: _____

Explanation: _____

Accreditation report attached: ☐ Yes ☐ No

Treatment Procedures

Please indicate procedures supplied by the ART provider at this site:

IVF ☐ GIFT ☐ ICSI ☐ AI ☐ PGD ☐ Gamete Storage ☐ Embryo Storage ☐

Other: _____

Storage Facility

Please indicate whether the following are stored by the ART provider at this site on a permanent or temporary basis (i.e. only while satellite clinic operating):

	Permanent	Temporary
Embryos	☐	☐
Sperm stored for medical/social reasons	☐	☐
Partner's sperm	☐	☐
Donor sperm	☐	☐
Donor eggs	☐	☐
Eggs stored for medical/social reasons	☐	☐
Ovarian tissue	☐	☐

Site 10

Contact Details

Name of site: _____

Address: _____

_____

Phone No: _____ Facsimile: _____

Email: _____ Website: _____

RTAC Accreditation

Please identify the current status of accreditation for this site with RTAC. If approval has been received, please note the date of approval and attach a copy of accreditation and accreditation report. If not approved, please attach a full explanation.

RTAC accredited: ☐ Yes ☐ No

Date: _____

Explanation: _____

Accreditation report attached: ☐ Yes ☐ No

Treatment Procedures

Please indicate procedures supplied by the ART provider at this site:

IVF ☐ GIFT ☐ ICSI ☐ AI ☐ PGD ☐ Gamete Storage ☐ Embryo Storage ☐

Other: _____

Storage Facility

Please indicate whether the following are stored by the ART provider at this site on a permanent or temporary basis (i.e. only while satellite clinic operating):

	Permanent	Temporary
Embryos	☐	☐
Sperm stored for medical/social reasons	☐	☐
Partner's sperm	☐	☐
Donor sperm	☐	☐
Donor eggs	☐	☐
Eggs stored for medical/social reasons	☐	☐
Ovarian tissue	☐	☐