



# Australian Government

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## Department of Health and Ageing

### ITA DOHA 309/1112 – PART H APPLICATION FORM

#### INVITATION TO APPLY (ITA) FOR FULL MEDICARE ELIGIBILITY FOR MAGNETIC RESONANCE IMAGING (MRI) BASED ON POTENTIAL AREAS OF NEED

For further information in relation to ITA DOHA 309/1112, please visit our web site at:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/pathol-di-mri-index>

If you have any queries or questions in relation  
ITA DOHA 309/1112, please forward them to:

[MRI.ITA@health.gov.au](mailto:MRI.ITA@health.gov.au)

Application registration Number (office use only)



**APPLICATION  
INVITATION TO APPLY (ITA DOHA 309/1112) FOR FULL  
MEDICARE-ELIGIBILITY FOR MAGNETIC RESONANCE  
IMAGING (MRI) BASED ON  
POTENTIAL AREAS OF NEED**

**Instructions**

Organisations applying must use the Application Form. The Application should be developed with regard to the instructions explained in **ITA DOHA 309/1112**.

The Application comprises of eleven (11) sections:

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## Information relating to ITA DOHA 309/1112 and ITA DOHA 309/1112 Application Form

### General

Personal information on this form is collected in order to assist Health with its evaluation of the Application and to enable Health to contact the Applicant. The information will be used only for the purpose for which it was provided and will not be disclosed except as authorised or required by law.

Allowance has been made on each page for up to two signatories. Health requires that at least one signature is on each page and if the person making the declaration has the authority to sign on behalf of the Applicant then one signature is all that is required. There is no requirement from Health for the second signature however an Applicant can utilise both if they so wish.

The **ITA DOHA 309/1112 Application Form** forms part of **ITA DOHA 309/1112**. If any part of **ITA DOHA 309/1112** conflicts with another part, that part higher in the following list shall take precedence:

- (a) the sections and clauses in the body of **ITA DOHA 309/1112**; then
- (b) the **ITA DOHA 309/1112** Application Form.

Health will not accept responsibility for any misunderstanding arising from the failure by an Applicant to comply with the conditions of the Application, or arising from any ambiguity in the Applicant's response.

Your Application must be developed with regard to the conditions explained in **ITA DOHA 309/1112** and must consider Health's objective (**Clause 35** of **ITA DOHA 309/1112** and [Schedule 2](#) of this Application) and address the Criteria described in **Part C** of **ITA DOHA 309/1112** and in [Schedule 4](#) to [Schedule 7](#) of this document, in preparing their Application.

A **NIL** response or a blank field in any part of this Application Form will be taken to mean that the Applicant does not wish to address the identified section.

### Copies of the Application

One original Application (including supplementary material) plus three (3) copies of the Application must be submitted to the place of lodgement by the **Closing Time**. An Application may be excluded from further consideration if the required numbers of copies are not provided.

The original is to be marked 'Original' and copies should be marked 'Copy No 1', and so on. In the event of any discrepancy between the copies and the original, the original will prevail. Health's decision about discrepancies is final.

All material, including the required number of copies of the Application and supplementary material (with the exception of where Health request supplementary material from an Applicant after the **Closing Time**) must be received by the **Closing Time**.

In addition, an electronic version of the Application, in Microsoft Word format should be supplied on a CD.

### Format of the Application

The Application should be presented in the following manner:

- (a) 11 point or 12 point font size;
- (b) font style to be either Arial or Times New Roman;
- (c) on A4 sized paper; and
- (d) single sided.

Any page of the Application that has information that the Applicant considers to be 'Commercial-in-Confidence', then the document should be classified as 'Commercial-in-Confidence' and should have a header and footer on each page with the words 'Commercial-in-Confidence'.

### Lodgement

Applications should:

- (a) be enclosed in a sealed envelope or other sealed container;
- (b) be addressed to the location for lodgement (see below);
- (c) be clearly marked: "**Invitation to Apply DOHA 309/1112 – MRI Areas of Need**" and the **Closing Time (2:00PM {AEDT} 22 June 2012)**; and
- (d) have the applying organisation's name and return address clearly marked on the envelope or container.

Applicants who do not comply with these instructions may, at the discretion of Health, be excluded from further consideration. The decision of Health in this regard is final.

Applications must be lodged with Health no later than **2:00PM {AEDT} 22 June 2012** and addressed to the location for lodgement as detailed in the table below.

<u>Hand/Courier Delivery</u>	<u>Mail Delivery</u>
<p style="text-align: center;"><b><u>ITA DOHA 309/1112</u></b></p> <p>Tender Box Department of Health and Ageing</p> <p>Sirius Building, Ground Floor Foyer, 23 Furzer Street WODEN ACT 2606</p>	<p style="text-align: center;"><b><u>ITA DOHA 309/1112</u></b></p> <p>Tender Box Department of Health and Ageing</p> <p>Sirius Building, Ground Floor Foyer, 23 Furzer Street WODEN ACT 2606</p>

The Tender Box is accessible for deliveries between the hours of 8:30am and 5:00pm Monday to Friday (public holidays excepted).

For further information or questions in relation to the project, please e-mail:

[MRI.ITA@health.gov.au](mailto:MRI.ITA@health.gov.au).

**SCHEDULE 1 – APPLICANTS DETAILS**

**Project Name:** ITA DOHA 309/1112

**1.1 - Applicant's Details**

(Complete all details and lodge with Application)

**Q1. Legal name of proposed contracting organisation or full name of individual**

**Q2. Registered business or trading name of organisation at Q1. (if applicable)**

**Q3. Registered business address of organisation at Q1 (not PO Box)**

**Q4. If Applicable:**

a) **LSPN<sup>1</sup>:**

b) **ACN<sup>2</sup>:**

c) **ABN<sup>3</sup>:**

If your organisation has a website, please provide the details:

**Q5. Website Address**

Signed by an authorised signatory or signatories of your organisation  
----- Date / / ----- Date / /

<sup>1</sup> Location Specific Practice Number

<sup>2</sup> Australian Company Number.

<sup>3</sup> Australian Business Number.

**Q6. How would you describe your organisation?  
(Please tick one or more boxes if applicable)**

<input type="checkbox"/> Aboriginal Corporation established under the Corporations (Aboriginal and Torres Strait Islander) Act 2006	<input type="checkbox"/> Sole Trader
<input type="checkbox"/> Proprietary company	<input type="checkbox"/> Partnership
<input type="checkbox"/> Company Limited by Guarantee	<input type="checkbox"/> Union (recognised under industrial legislation)
<input type="checkbox"/> Unlisted Public company	<input type="checkbox"/> Incorporated Association
<input type="checkbox"/> Listed Public Company	<input type="checkbox"/> Unincorporated Association
<input type="checkbox"/> Local Government Council	<input type="checkbox"/> Registered Charity
<input type="checkbox"/> Australian Government or State Government Authority or Corporation	<input type="checkbox"/> Trust/Unit Trust
<input type="checkbox"/> Australian Government or State Government Department.	<input type="checkbox"/> Other (including Chartered Entities), please specify in the space below

**Q7. All companies, registered associations, chartered entities and any entity using a trade name, must attach a copy of:**

Certificate of Incorporation; OR  
 Certificate of Charter; AND/OR  
 Registration of Business Name (if applicable).  
**(For each copy enclosed please tick the appropriate box above.)**

Entities incorporated directly under State or Federal Legislation are exempt from this requirement but must supply legislation reference details in **Question 8 (c)**.

Signed by an authorised signatory or signatories of your organisation

----- Date / / ----- Date / /

**Q8. Provide the following identifying details of the organisation named at Q1 (as applicable):**

(a) ACN<sup>4</sup>:

(b) ABN<sup>5</sup>:

(c) Registration Number under legislation other than the *Corporations Act 2001*:

State/Territory of Registration:

Legislation under which the above Registration Number has been issued (for example: *Queensland Associations Incorporation Act 1981* OR *South Australian Co-Operatives Act 1997*):

**Q9. If not already incorporated under the *Corporations Act* or a State incorporated association's law, does your organisation intend to incorporate prior to signing of the agreement?**

No

Yes → Please provide details:      Date you expect to be incorporated:      .      .      .

State or Territory of expected incorporation:

---

<sup>4</sup> Australian Company Number.  
<sup>5</sup> Australian Business Number.

Signed by an authorised signatory or signatories of your organisation  
 ----- Date / / ----- Date / /

**Q10. Please provide details of ALL RELEVANT people directly involved with the project and/or organisation. Relevant people are people with the potential to exert significant influence over the management/operation of the project. Examples of relevant people would be directors, partners, presidents, executive directors, project managers.**  
**Important Note:** All of the requested information is required to ensure that Health obtains accurate information about the correct individual from the databases that it accesses. Missing, incomplete, inaccurate or illegible details that do not allow Health to accurately identify an individual may delay assessment of your Application or result in your Application being eliminated from consideration.

1. Full Name (No abbreviations or initials):		Date of Birth:	
<input type="text"/>		<input type="text"/>	<input type="text"/>
Residential address (must have Street Name):		Position in Organisation:	
<input type="text"/>		<input type="text"/>	
Number of years in position of influence in Organisation:		<input type="text"/>	

2. Full Name (No abbreviations or initials):		Date of Birth:	
<input type="text"/>		<input type="text"/>	<input type="text"/>
Residential address (must have Street Name):		Position in Organisation:	
<input type="text"/>		<input type="text"/>	
Number of years in position of influence in Organisation:		<input type="text"/>	

3. Full Name (No abbreviations or initials):		Date of Birth:	
<input type="text"/>		<input type="text"/>	<input type="text"/>
Residential address (must have Street Name):		Position in Organisation:	
<input type="text"/>		<input type="text"/>	
Number of years in position of influence in Organisation:		<input type="text"/>	



Signed by an authorised signatory or signatories of your organisation	
----- Date / / -----	----- Date / / -----

<b>4. Full Name (No abbreviations or initials):</b>	<b>Date of Birth:</b>
<b>Residential address (must have Street Name):</b>	<b>Position in Organisation:</b>
<b>Number of years in position of influence in Organisation:</b>	

<b>5. Full Name (No abbreviations or initials):</b>	<b>Date of Birth:</b>
<b>Residential address (must have Street Name):</b>	<b>Position in Organisation:</b>
<b>Number of years in position of influence in Organisation:</b>	

<b>6. Full Name (No abbreviations or initials):</b>	<b>Date of Birth:</b>
<b>Residential address (must have Street Name):</b>	<b>Position in Organisation:</b>
<b>Number of years in position of influence in Organisation:</b>	

**If you require additional entries, copy this page and insert before  
1.2 – CONTACT DETAILS**

Signed by an authorised signatory or signatories of your organisation	
----- Date / /	----- Date / /

**1.2 - Contact Details**

(Complete all details and lodge with Application)

**Contact during business hours**

Location where the Applicant can be contacted between the hours of 8:00am and 6:00pm (Australian Eastern Daylight Time) Monday to Friday (public holidays excluded):

<b>Contact Name</b>			
<b>Position</b>			
<b>Business (Physical) Address</b>			
<b>Postal Address</b>			
<b>Telephone Number</b>	<b>Mobile Phone Number</b>	<b>Fax Number</b>	
<b>Email</b>			

**Contact after working hours**

Provide the name and contact details for the nominated contact for the Application after the specified hours above, weekends and public holidays:

<b>Contact Name</b>			
<b>Telephone Business Hours</b>		<b>After Hours</b>	

Signed by an authorised signatory or signatories of your organisation			
-----	Date	/	/
-----	Date	/	/



**1.4 - Management Committee**

**Are you submitting an Application as the lead member of a Consortium which involves a Management Committee?**

<b>Yes</b>	<input type="checkbox"/>	<input type="checkbox"/> complete the table below
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<b>No</b>	<input type="checkbox"/>	place 'Not Applicable' on line 1 and go to <b>1.5 Insurance</b>
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Please provide details of all committee members in the table below.

Name	Contact details (phone and email address)	Position on the Management Committee	Stakeholder Group

**If you require additional entries, copy the above table and insert before 1.5. SCHEDULE OF INSURANCE.**

Signed by an authorised signatory or signatories of your organisation

----- Date / / ----- Date / /

**1.5 - Insurance**

(Complete all details and lodge with Application)

**Workers Compensation**

<b>NOTE: Applicants are to delete (i) or (ii) as appropriate.</b>		
<b>(i) For Applicants employing workers (as defined in "Work Health Act" (1986) as amended).</b>	<b>(ii) For Applicants <u>not</u> employing workers (as defined in "Work Health Act" (1986) as amended).</b>	
<b>Policy Number</b>		<b>I/We certify that I/we am/are not employing nor intending to employ workers (as defined in "Work Health Act" (1986) as amended).</b>
<b>Name of Insurer</b>		
<b>Date of Expiry</b>		

**Public Liability**

<b>Policy Number</b>		<b>Name of Insurer</b>	
<b>Date of Expiry</b>		<b>Sum Insured (per claim)</b>	

**Professional Indemnity Insurance**

<b>Policy Number</b>		<b>Name of Insurer</b>	
<b>Date of Expiry</b>		<b>Sum Insured</b>	

Signed by an authorised signatory or signatories of your organisation	
----- Date / /	----- Date / /

### 1.6 - Conflict of Interest

(Complete all details and lodge with Application)

**Note to Applicants: Refer to ITA DOHA 309/1112 – Clause 23.**

The Applicant must declare any conflict of interest that exists or is likely to exist if the Applicant was successful in being selected to provide the Medicare benefits eligible MRI services. If no conflict exists, the Applicant should note this below.

The Applicant should also set out its proposed strategy for managing any such conflict.

#### Is there a conflict of interest or potential conflict of interest?

<b>Yes</b>		<input type="checkbox"/> <input type="checkbox"/> complete the table below
------------	--	--

<b>No</b>		<input type="checkbox"/> place 'Not Applicable' in section A and go to <b>1.7 – Applicant's Proposed Confidential Information</b>
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<b>A. Detail any perceived, potential or actual conflict of interest that your organisation or office bearers may have or may arise in the delivery of the Project</b>
--

**If you require additional space to fully address the requirement, copy the above box and insert before PART B. OF SCHEDULE 1.6**

Signed by an authorised signatory or signatories of your organisation
----- Date / / ----- Date / /

**B. Describe conflict of interest management strategy should a conflict of interest arise**

**If you require additional space to fully address the requirement, copy the above box and insert before 1.7 – APPLICANT'S PROPOSED CONFIDENTIAL INFORMATION**

Signed by an authorised signatory or signatories of your organisation

----- Date / / ----- Date / /



**1.7 - Applicant's Proposed Confidential Information**

(Complete all details and lodge with Application)

**Note to Applicants: Refer to ITA DOHA 309/1112 – Clause 32.5**

Applicants should list here any information which they will be providing in the Application or during the Application process that they consider should be protected as confidential information, if an agreement is entered into between the Applicant and Health. If no information is listed, Health will assume that there is no confidential information in the Application.

The Applicant should provide reasons why this information should be protected as confidential information.

Applicants should note that Health will consider each request to keep information confidential on its merits. Whether or not Health will agree to a request to keep information confidential will depend on the circumstances and negotiations with the successful Applicant.

Health reserves the right, at its discretion, to accept or refuse a request to treat information as confidential.

Health will use the criteria set out in the *Australian National Audit Office's Report Number 38 /2000 - 2001 (The Use of Confidentiality Provisions in Government Contracts)* as a guide when determining whether to accept a claim for confidentiality. The ANAO identified the following types of information which would generally not be considered to be confidential:

- (a) Performance and financial guarantees;
- (b) Indemnities;
- (c) The price of an individual item, or groups of items of goods or services;
- (d) Rebate, liquidated damages and service credit clauses;
- (e) Performance measures that are to apply to the contract;
- (f) Clauses which describe how intellectual property rights are to be dealt with; and
- (g) Payment arrangements.

The ANAO's report also listed examples of what would usually be considered confidential. These are:

- (a) Trade secrets, such as inventions, engineering and design drawings, craft secrets;
- (b) Proprietary information of contractors (this could be information about how a particular technical or business solution is to be provided);
- (c) A contractor's internal costing information or information about its profit margins; and
- (d) Pricing structures (where this information would reveal whether a contractor was making a profit or loss on the supply of a particular good or service).

Is there any Confidential Information the Applicant wishes to declare?

<b>Yes</b>		<input type="checkbox"/> <input type="checkbox"/> complete the table below
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<b>No</b>		<input type="checkbox"/> place Not Applicable on line 1 and go to <b>1.8. List of Attachments</b>
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Signed by an authorised signatory or signatories of your organisation							
	Date	/	/		Date	/	/





## 1.9 – Privacy and Confidentiality

### Privacy Notice

The Department of Health and Ageing (Health) collects any personal information sought in this Questionnaire so that it can check the Applicant's suitability to undertake work for the Australian Government. Health may use this information to obtain further information about the Applicant and/or any named individuals from Health's own records and databases, publicly available records of the Australian Securities and Investment Commission and/or a credit rating agency. This information will only be used by Health in relation to the Applicant's current or future Applications for the purpose of verifying information provided and to identify any adverse information that has not been disclosed, or that may adversely affect the Applicant's ability to meet its obligations under the agreement. Health is obliged to protect any personal information about individuals in accordance with the provisions of the *Privacy Act 1988*.

### Confidentiality of Information

If this questionnaire is required as part of the Invitation to Apply (ITA) or Application process then the provisions regarding confidentiality of information that are established in ITA DOHA 309/1112 or Application documentation apply to the information in this questionnaire and supporting documents. If the ITA or Application documentation does not address confidentiality of information, or this questionnaire is not part of such a process, then the following applies:

Health operates within a public accountability framework which requires it to ensure openness and transparency of its activities. This requires Health to minimise the amount of information that is subject to confidentiality requirements. The overriding principle applied by Health is that information should not be protected as confidential unless there is good reason to do so. Organisations completing this questionnaire are asked to identify in writing any information that they consider should be protected as confidential information under the agreement, including reasons for the request. Health may request further information from an organisation about its claim for confidentiality and that information must be provided within three (3) business days after the request.

If the organisation does not identify any information as confidential (Schedule 1.7) Health will consider that the organisation has no information which should be protected as confidential under the agreement. Health reserves the right, at its sole discretion, to accept or refuse a request to treat information as confidential. If Health and the organisation enter into an agreement, the information which is to be protected as confidential will be listed in the Schedule to the resulting agreement.

If Health and a preferred organisation enter into negotiations and Health does not accept that organisation's request to treat information as confidential, Health will notify the organisation in writing of the decision. Unless Health and the organisation reach agreement within five (5) business days after the notification, Health reserves the right not to enter into an agreement with that organisation and to enter into an agreement with another organisation.

Signed by an authorised signatory or signatories of your organisation

----- Date / / ----- Date / /

- Health will treat as confidential, information which is provided in response to this questionnaire and is:
- (a) provided by organisations which ultimately do not receive Health's support for their activity; and
  - (b) which is not otherwise in the public domain.

**Exceptions to Confidentiality**

Health's obligation to keep an organisation's information confidential will not be breached if the information:

- (a) is disclosed by Health to its advisers, officers, employees or subcontractors in order to conduct the **ITA DOHA 309/1112** process;
- (b) is disclosed to Health's internal management personnel, solely to enable effective management or auditing of the **ITA DOHA 309/1112** process;
- (c) is disclosed by Health to the responsible Minister;
- (d) is disclosed by Health in response to a request by a House or a Committee of the Parliament of the Commonwealth of Australia;
- (e) is disclosed by Health within the Commonwealth or with a Commonwealth agency;
- (f) is authorised or required by law to be disclosed;
- (g) is in the public domain otherwise than due to a breach of Health's obligations of confidentiality under **ITA DOHA 309/1112**; or
- (h) is disclosed by Health with the written consent of the Applicant.

Organisations should note the sections in the ITA documentation which provide for access to records under the *Freedom of Information Act 1982*, the *Auditor-General Act 1997* and the *Ombudsman Act 1976*. Parliament and the courts also have legal rights to access to a wide range of information.

Signed by an authorised signatory or signatories of your organisation	
----- Date / /	----- Date / /

**SCHEDULE 2 – SPECIFICATION**

**Project Name: ITA DOHA 309/1112**

**Objective**

- The objective of **ITA DOHA 309/1112** is to ensure patients in identified areas of need have access to Medicare benefits eligible MRI services.
- That MRI services provided in identified areas of need are of a high quality, and performed by appropriately qualified Radiologist, within a comprehensive accredited diagnostic imaging practice.
- To ensure Medicare-eligible MRI services are provided in accordance with the provisions of the *Health Insurance Act 1973* and regulations made under the Act.

**Policy Context**

- Previous expansions of MRI Medicare eligibility have generally defined a number of geographical areas that were considered to be areas of need, and then invited interested providers to apply to provide Medicare-eligible MRI services in those areas. Given the planned expansion of Medicare-eligible MRI services under the Package from 1 November 2012 there are potentially fewer geographical areas likely to be identified as areas of need.
- The department is of the view that an area of need process based solely on geographical distribution may overlook other important areas of need such as:
  - locations where units with partial Medicare eligibility may seek full eligibility;
  - patient groups with particular service needs; and
  - locations where a Medicare-eligible MRI would improve service integration.
- In addition to geographical considerations, the Department has identified two alternative approaches to identify areas of need, patient and health service integration.
- **ITA DOHA 309/1112** has two purposes. First, to inform the Department of areas where there may be both a need for Medicare-eligible MRI services and a provider who would be willing to provide them. Secondly, to assist the Department to consider allocation of Medicare eligibility to 12 MRI units between 2012 and 2015.

**Area of Need streams**

- The department has identified three area of need streams (see below). When responding to the weighted criteria Applicants will be required to select two areas of need streams, the first will be a primary/major stream, and the second will be your secondary/minor stream.

AREA OF NEED STREAMS		
Patient Groups	Health Service Integration	Geographical distribution
This stream focuses on specific patient groups. These patient groups are based on physical attributes, clinical conditions, and/or populations that deviate from the standard patient profiles.	This stream focuses on integration with local health services to increase access to health service provision, as well as alignment with other major Government investments in health services and infrastructure.	This stream focuses on specific locations determined by current access to Medicare-eligible MRI services.

Signed by an authorised signatory or signatories of your organisation

----- Date / / ----- Date / /

**SCHEDULE 3 – PROBITY CONSENTS**

*Note to Applicants: Refer to ITA DOHA 309/1112 – Clause 22.*

**Project Name: ITA DOHA 309/1112**

**REQUEST FOR CONSENT TO OBTAIN COMPANY AND PERSONAL INFORMATION**

ITA DOHA /1112 requires Applicants to provide Health with information relating to issues such as corporate structure, current operations, and legal matters that may be affecting the Applicant. As part of the evaluation of Applications, Health may wish to undertake verification checks with:

- (a) the Australian Federal Police and/or the Police Services of the States or Territories of the Commonwealth of Australia and/or other relevant police force(s); and
- (b) the Australian Securities and Investments Commission.

in relation to information that they may hold relating to Applicants.

Attached are copies of a consent form and letters to the agencies for the particular checks that Health would like to undertake. The completed consent to obtain company and personal information should be included with the Application.

During the ITA process, Health may require the Applicant to provide (or procure from its associates and officers etc) consents for other investigations by Health.

Each Applicant's attention is drawn to **Clause 22** of **ITA DOHA 309/1112** in relation to probity checks.

Signed by an authorised signatory or signatories of your organisation

----- Date / / ----- Date / /

**Authority for use by individuals**

**To be completed by all directors (including the Managing Director), the Chairman, and the Chief Executive Officer of the Company/statutory authority, or where the Applicant is a partnership, by all partners, or where the Applicant is a government entity – the Chief Executive Officer of the entity**

**NO EXCLUSION**

**Commonwealth of Australia  
CONSENT TO OBTAIN PERSONAL INFORMATION**

(for categories where **NO EXCLUSION** has been granted from spent convictions legislation)

I..... (Full name of officer - **BLOCK LETTERS** and in **INK**) hereby:

- (i) understand that I do not have to disclose old protected convictions information covered by Part VIIC of the *Crimes Act 1914* dealing with spent convictions;
- (ii) certify that the personal information I have provided on the attached form relates to me and is complete and correct;
- (iii) consent to the Department of Health and Ageing ("**Health**") and its advisers forwarding the attached form to the Australian Federal Police and/or the Police Services of the States or Territories of the Commonwealth of Australia and/or other relevant police force(s) (the "**Police**") and for the Police to provide relevant information to Health;
- (iv) consent to the Police extracting from their records details of convictions or findings of guilt which have been recorded against me and which are not covered by Part VIIC of the *Crimes Act 1914* dealing with spent convictions;
- (v) acknowledge that any information provided by me on this Form or by the Police as a result of the records check may be taken into account in relation to the consideration and assessment of Applications for the Invitation to Apply **DOHA /1112** – Full Medicare eligibility for MRI based on Potential Areas of Need, or part(s) thereof, by or for and on behalf of the Australian Government (including Health) and its agencies.

Signature .....

Date            /            /

**Note: The information contained on this form will not be used without your prior consent for any purpose other than in relation to the consideration and assessment of Applications to provide a Medicare benefits eligible MRI services.**



**Personal Particulars**

**No Exclusion  
(Reverse)  
Please Print**

Surname (present)	All other surnames used	
Christian or given names		Sex Male    Female
Date of Birth	Town / city of birth	State / country of birth
Contact phone Number	Drivers licence number	State

**Permanent Residential Address Over Last Ten Years**

If full details of previous addresses are unavailable details of town(s) and state(s) will suffice. <i>Attach list if insufficient room.</i>	If actual dates are unavailable, Details of year of residence will suffice.
Current	Period of residence
	/       /       to /       /
	/       /       to /       /
	/       /       to /       /
	/       /       to /       /
	/       /       to /       /

**CRIMINAL CHARGE, CONVICTION OR PECUNIARY PENALTIES**

(i) Are you the subject of any criminal charge(s) still pending before a court	YES	NO
(ii) Do you have any conviction(s) or finding(s) of guilt which are less than ten (10) years old, or any juvenile conviction(s) or finding(s) of guilt which are less than five (5) years old?	YES	NO
(iii) Do you have any conviction(s) or finding(s) of guilt which are over ten (10) years old, YES (or five (5) years for juvenile conviction(s) or finding(s) of guilt) where the sentence imposed was <u>greater</u> than thirty (30) months imprisonment?	NO	

**If you answered YES to any of the above questions, please attach details:**

<p><b>Address of Initiating Department</b> User Code: (to be inserted by Department)</p>	<p style="text-align: center;"><b>Police Use Only</b> <b>Australian Federal Police</b> NOT RECORDED / RECORDED</p> <p>NOTE: As fingerprints do not accompany your request, the Australian Federal Police cannot guarantee in any manner, that the information supplied herewith concerns the individual in whom you are interested.</p> <p>Signature..... Date: For Commissioner Australian Federal Police</p>
--	--

**To be completed by all directors (including the Managing Director), the Chairman, and the Chief Executive Officer of the Company**

**[Full name, residential address and date of birth of individual]**

Telephone: **[business, after hours and mobile]**

**[date]**

Office of the Chairman  
Australian Securities and Investments Commission  
PO BOX 4000  
Gippsland Mail Centre  
Victoria 3841

Dear Sir/Madam

This letter authorises the Australian Securities and Investments Commission ("ASIC") to disclose to and discuss with the Department of Health and Ageing ("Health") and its advisers any material or information concerning or relating to me which the ASIC considers relevant to a due consideration and assessment by Health of the Application to provide a Medicare benefits eligible MRI services by **[name of Applicant]** ("Applicant") and my involvement as a **[office(s) or position(s) held]** in **[name(s) of company(ies)]** and its participation in that Application.

I confirm that I have nothing to disclose in respect of any litigation, proceeding, judicial or administrative enquiry, investigation, claim or allegation by the ASIC against or in any way involving me or the Applicant, nor are there any matters involving me or the Applicant which ought to be brought to the ASIC's attention **[or provide details of matters to be disclosed]**.

I am or have previously been a **[list office(s) or position(s) held]** of **[list names of all Australian companies in which you have held an office]**.

Yours sincerely

**[Signature and name of individual]**

**To be completed by the Company**

**[Company's letterhead]**

**[date]**

Office of the Chairman  
Australian Securities and Investments Commission  
PO BOX 4000  
Gippsland Mail Centre  
Victoria 3841

Dear Sir/Madam

This letter authorises the Australian Securities and Investments Commission (“**ASIC**”) to disclose to and discuss with the Department of Health and Ageing (“**Health**”) and its advisers any material or information concerning or relating to **[name of Company]** (“**Company**”) which ASIC considers relevant to a due consideration and assessment by Health of the Application to provide a Medicare benefits eligible MRI services and the Company's participation in that Application.

I confirm that, the Company has nothing to disclose in respect of any litigation, proceeding, judicial or administrative enquiry, investigation, claim or allegation by ASIC against or in any way involving the Company, nor are there any matters involving the Company which ought to be brought to ASIC's attention **[or provide details of matters to be disclosed]**.

I am duly authorised by the Company to sign this letter on its behalf.

Yours sincerely

**[signature]**

**[Full name of signatory]**

**[Position/title of signatory]**

**SCHEDULE 4 – ESSENTIAL CRITERIA**

**Note to Applicants: Refer to ITA DOHA 309/1112 – Clause 48.8.**

**Project Name: ITA DOHA 309/1112**

**Note to Applicants: See Clause 48.8 of ITA DOHA 309/1112 - Essential Criteria.**

The Applicant **must** confirm to Health by ticking the box next to the paragraph that:

1. the MRI unit will be able to, and will continue to provide the full range of MRI services listed in the *Health Insurance (Diagnostic Imaging Services table) Regulations*.   
(<http://www.comlaw.gov.au/Series/F2011L02123>)
2. the Applicant is an established MRI provider and are currently providing MRI services to patients; or   
when the Applicant intends to establish an MRI service.
3. the DI Practice or Medical practice, will commit to becoming accredited under the Diagnostic Imaging Accreditation Scheme (DIAS) if identified as the successful applicant/s.   
(<http://www.health.gov.au/internet/main/publishing.nsf/Content/diagnosticimaging-accred2>)
4. the Applicant will comply with all relevant legislation in establishing and operating a Medicare-eligible MRI service
5. the MRI unit will be, and continue to be, located at premises of a comprehensive practice.   
  
**comprehensive practice** is a   
medical practice, or a radiology department of a hospital, that  
provides x-ray, ultrasound and computed tomography services  
(whether or not it provides other services)

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /

6. The Applicant must provide the street address or proposed street address for the MRI service.

<b>Street Number</b>	
<b>Street Name</b>	
<b>Suburb</b>	
<b>City/Town</b>	
<b>State</b>	
<b>Post Code</b>	

Is this address located in a hospital?

<b>Yes</b>		<input type="checkbox"/> <input type="checkbox"/> ensure <a href="#">Schedule 8</a> is completed.
<b>No</b>		

Is this address a public hospital?

<b>Public</b>		<input type="checkbox"/> <input type="checkbox"/> ensure <a href="#">Schedule 8</a> is completed.
<b>Private</b>		

Is the practice a private or public practice?

<b>Public</b>	
<b>Private</b>	

<b>Applicant's response</b>

**If you require additional space to fully address the requirement, copy the above box and insert before SCHEDULE 5: PRIMARY ASSESSMENT/ WEIGHTED CRITERIA**

Signed by an authorised signatory or signatories of your organisation	
-----Date / /	-----Date / /

**SCHEDULE 5 – PRIMARY ASSESSMENT / WEIGHTED CRITERIA**

**Project Name: ITA DOHA 309/1112**

The Weighted Criteria for the evaluation of best value for money for Health overall, [noting the objective in **Clause 35**, are set out below. Each Applicant's attention is drawn to **Clause 35** of the ITA in preparing its Application

In order to enable an effective evaluation of an Application, Applicants are strongly encouraged to respond to **all** of the following Weighted Criteria in detail. **A failure to respond to any paragraph of a Weighted Criterion may lead to an Applicant's Application not being evaluated.**

<b>CRITERION ONE – PRIMARY STREAM</b>	<b>WEIGHTING – 60%</b>
<ul style="list-style-type: none"> <li>As detailed in Clause 37.1, Applicants must identify a primary area of need stream in this criterion; and</li> <li>Applicants need to respond to all of the sub criteria listed under the stream identified as your primary stream.</li> <li>Applicants should note that this Primary Stream attracts a 60% weighting.</li> </ul>	
<p><b>PRIMARY AREA OF NEED STREAM:</b> _____</p> <p>Applicants must demonstrate knowledge and understanding of patient needs and how the establishment of a Medicare-eligible MRI service in the identified area of need will improve patient access and contribute to better health outcomes.</p> <p><u>Patient Group Stream:</u> or</p> <p>(a) What is the Identified Patient Group and the estimated number of patients?</p> <p>(b) Why do you consider the identified Patient Group an area of need?</p> <p>(c) How do the health outcomes of the identified Patient Group compare to the broader population?</p> <p>(d) How would access to Medicare-eligible MRI services at the proposed location improve access to MRI services, for the identified Patient Group and other interventions contingent upon an MRI scan?</p> <p>(e) How would improved access to MRI service improve the health outcomes of the identified Patient Group?</p> <p><u>Health Service Integration:</u> or</p> <p>(f) What other health service facilities are available in identified area?</p> <p>(g) How does the existing health infrastructure in the area contribute to patient health outcomes?</p> <p>(h) How will a Medicare-eligible MRI service integrate within the identified health service infrastructure</p> <p>(i) How would a Medicare-eligible MRI service improve patient access to MRI services and other interventions contingent upon an MRI scan?</p> <p>(j) How will a Medicare-eligible MRI service improve patient health outcomes beyond the current health services available to patients?</p>	

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /

Geographical

- (k) How many MRI services are available in the identified area?
- (l) What distance (in Kilometres) is the nearest Medicare-eligible MRI service to the identified location?
- (m) What is the projected patient catchment area of the identified location?
- (n) What is the population and does the population overlap with that of the closest Medicare-eligible MRI service?
- (o) How many requesting specialists and GPs deliver services to patients in the catchment area either through a local practice or through an established telehealth network?

**Each Applicant's attention is drawn to Clause 35 of the ITA in preparing its Application**

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /

**Response to Weighted Criterion One (1) – Page 1**

**Primary Area of Need Stream: (Select one only)**

- Patient Group.....
- Geographical.....
- Health Service Integration.....

**If you require additional space to fully address the requirement, copy the above box and insert before CRITERION TWO – SECONDARY STREAM.**

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /



<b>CRITERION TWO – SECONDARY STREAM</b>	<b>WEIGHTING – 20%</b>
<ul style="list-style-type: none"> <li>As detailed in Clause 37.1, Applicants must identify a primary area of need stream in this criterion; and</li> <li>Applicants need to respond to all of the sub criteria listed under the stream identified as your primary stream.</li> <li>Applicants should note that this Primary Stream attracts a 20% weighting.</li> </ul>	
<p><b>SECONDARY AREA OF NEED STREAM:</b> _____</p>	
<p>Applicants must demonstrate knowledge and understanding of patient needs and how the establishment of a Medicare-eligible MRI service in the identified area of need will improve patient access and contribute to better health outcomes.</p>	
<p><u>Patient Group Stream:</u> or</p>	
<p>(a) What is the Identified Patient Group and the estimated number of patients?</p>	
<p>(b) Why do you consider the identified Patient Group an area of need?</p>	
<p>(c) How do the health outcomes of the identified Patient Group compare to the broader population?</p>	
<p>(d) How would access to Medicare-eligible MRI services at the proposed location improve access to MRI services, for the identified Patient Group and other interventions contingent upon an MRI scan?</p>	
<p>(e) How would improved access to MRI service improve the health outcomes of the identified Patient Group?</p>	
<p><u>Health Service Integration:</u> or</p>	
<p>(f) What other health service facilities are available in identified area?</p>	
<p>(g) How does the existing health infrastructure in the area contribute to patient health outcomes?</p>	
<p>(h) How will a Medicare-eligible MRI service integrate within the identified health service infrastructure?</p>	
<p>(i) How would a Medicare-eligible MRI service improve patient access to MRI services and other interventions contingent upon an MRI scan?</p>	
<p>(j) How will a Medicare-eligible MRI service improve patient health outcomes beyond the current health services available to patients?</p>	

Signed by an authorised signatory or signatories of your organisation	
-----Date / /	-----Date / /

Geographical

- (k) How many MRI services are available in the identified area?
- (l) What distance (in Kilometres) is the nearest Medicare-eligible MRI service to the identified location?
- (m) What is the projected patient catchment area of the identified location?
- (n) What is the population and does the population overlap with that of the closest Medicare-eligible MRI service?
- (o) How many requesting specialists and GPs deliver services to patients in the catchment area either through a local practice or through an established telehealth network?

**Each Applicant's attention is drawn to Clause 35 of the ITA in preparing its Application**

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /

Each Applicant's attention is drawn to Clause 35 of the ITA in preparing its Application.

**Response to Weighted Criterion Two (2) – Page 1**

Secondary Area of Need Stream: (Select one only)

- Patient Group.....
- Geographical.....
- Health Service Integration.....

**If you require additional space to fully address the requirement, copy the above box and insert before CRITERION THREE – PATIENT ACCESS/ INFRASTRUCTURE.**

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /

<b>CRITERION THREE – PATIENT ACCESS/INFRASTRUCTURE</b>	<b>WEIGHTING – 20%</b>
<ul style="list-style-type: none"> <li>• Applicants need to respond to all sub criteria listed below.</li> <li>• Applicants should note that this Criterion attracts a 20% weighting.</li> </ul>	
How will patient access improve in relation to your identified area of need?	
<ul style="list-style-type: none"> <li>(a) the proximity and availability of safe, appropriate, and convenient public transport facilities to the proposed MRI site;</li> <li>(b) the proximity of public and private hospitals to the proposed MRI site;</li> <li>(c) the proximity and availability of services, retail areas and other medical services to the proposed MRI site, and</li> <li>(d) the physical accessibility to patients, including people with disabilities.</li> </ul>	
Applicants must demonstrate they have, or will have the required infrastructure to provide the full range of MRI services on the Medicare Benefits Schedule	
<ul style="list-style-type: none"> <li>(e) The range of services available, including sedation and anaesthesia, at the proposed MRI site;</li> <li>(f) The proposed reporting times (i.e. time between imaging and reporting back to the requesting doctors);</li> <li>(g) How information in relation to all aspects of the proposed MRI service (including operating hours and costs) will be provided to patients and requesting doctors prior to, during and after the MRI service; and</li> <li>(h) Any other issues the Applicant considers are appropriate in relation to accessibility, to the proposed MRI site.</li> </ul>	

Signed by an authorised signatory or signatories of your organisation	
-----Date / /	-----Date / /

**Response to Weighted Criterion Three (3) – Page 1**

**If you require additional space to fully address the requirement, copy the above box and insert before SCHEDULE 6 – PRIMARY ASSESSMENT/ NON-WEIGHTED CRITERIA**

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /

**SCHEDULE 6 – PRIMARY ASSESSMENT/ NON - WEIGHTED CRITERIA**

**Project Name: ITA 309/1112**

The Weighted Criteria for the evaluation of best value for money for Health overall, [noting the objective in **Clause 35**, are set out below. Each Applicant's attention is drawn to **Clause 35** of the ITA in preparing its Application

In order to enable an effective evaluation of an Application, Applicants are strongly encouraged to respond to **all** of the following Weighted Criteria in detail. **A failure to respond to any paragraph of a Weighted Criterion may lead to an Applicant's Application not being evaluated.**

**CRITERION FOUR – PROVISION OF MRI SERVICES NON- WEIGHTED**

- Applicants need to respond to all of the sub criteria listed below.
- Demonstrated knowledge, understanding and awareness of the Australian Government's objective for providing Medicare-eligible MRI services.  
Applicants need to respond to all of the following paragraphs in the business plan submitted as part of their Application:
- (a) Do you have an established Diagnostic Imaging practice?(\*)  
*If no, identify when will the Diagnostic Imaging practice be established?*
- (b) Does your practice currently provide Computed tomography (CT), X-Ray, and ultrasound services?  
*If no, identify when these services will be established to form a comprehensive practice (Clause 48.8).*
- (c) Do you have an MRI unit within the aforementioned DI practice?  
*If yes, identify if the MRI unit is operational and when it commenced providing MRI services to patients.*  
*If yes, has your DI practice sought partial Medicare-eligibility from Health under the Government's Diagnostic Imaging Review Reform Package 2011-12?*
- (d) If you were to be awarded Medicare-eligibility, when will you commit to the MRI unit becoming operational? (NB. This timing will be reflected in any agreement with Health as a mandatory condition and should a successful applicant fail to establish the MRI service by this date the Department reserves the right to reconsider the outcome and allocate Medicare eligibility to a different provider.)
- 2012      *Specify date: \_dd/mm/yy\_*
  - 2013      *Specify date: \_dd/mm/yy\_*
  - 2014      *Specify date: \_dd/mm/yy\_*
  - 2015      *Specify date: \_dd/mm/yy\_*
- (\**) As per the requirements of the Deed of Undertaking (Part E), Health will give due consideration to a request to change the location of eligible equipment.*

Signed by an authorised signatory or signatories of your organisation  
 -----Date / / -----Date / /

**Response to Non-Weighted Criterion Four (4) – Page 1**

**If you require additional space to fully address the requirement, copy the above box and insert before CRITERION FIVE – BUSINESS/ OPERATION STRUCTURE**

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /

<b>CRITERION FIVE – BUSINESS/OPERATION STUCTURE</b>	<b>NON- WEIGHTED</b>
<ul style="list-style-type: none"><li>• Applicants need to respond to all of the sub criteria listed below.</li><li>• Applicants need to respond to all of the following paragraphs in the business plan submitted as part of their Application that staff are in place to provide the MRI service, or strategies for recruitment</li></ul>	
<p>Demonstrated knowledge, understanding and awareness of the Australian Government’s objective for providing MRI services.</p> <ul style="list-style-type: none"><li>(a) the staffing levels required to operate a high quality MRI service (including expertise);</li><li>(b) the methodology for ensuring that staff are appropriately trained to provide a high quality MRI service;</li><li>(c) what staff will be available (including their expertise);</li><li>(d) the arrangements (if any) that will be in place for the provision of emergency care;</li><li>(e) whether the use of telehealth networks will be available for this MRI service; and</li><li>(f) the Applicant’s record of achieving business outcomes.</li></ul>	

Signed by an authorised signatory or signatories of your organisation	
-----Date / /	-----Date / /



**Response to Non-Weighted Criterion Five (5) – Page 1**

**If you require additional space to fully address the requirement, copy the above box and insert before SCHEDULE 7 – SECONDARY ASSESSMENT**

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /



**Response to Weighted Criterion Six (6) – Page 1**

**If you require additional space to fully address the requirement, copy the above box and insert before SCHEDULE 8 – SUPPORTING STATEMENT**

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /

**SCHEDULE 8 – SUPPORTING STATEMENT**

**Project Name:** ITA DOHA 309/1112

**Does your Application involve the siting of an MRI service within a hospital (private or public)?**

<b>Yes</b>	<input type="checkbox"/>	please attach a Letter of Support from the hospital involved.
------------	--------------------------	---

<b>No</b>	<input type="checkbox"/>
-----------	--------------------------

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /

**SCHEDULE 9 – STATEMENT OF COMPLIANCE/AGREEMENT**

**Note to Applicants:** Refer to ITA DOHA 309/1112 – Clause 15.

**Project Name:** ITA DOHA 309/1112

ITA DOHA 309/1112 consists of three (3) Sections and Applicants are to state their compliance/agreement that they have read, taken advice on and fully understand the requirements Health seek with each section of ITA DOHA 309/1112. Where an Applicant does not comply/agree with a particular Section of this ITA, the extent of non-compliance/non-agreement should be stated in the spaces provided within this Schedule. The Applicant must also provide reasons for the non-compliance/non-agreement and details of any alternative proposal.

A **NIL** response or a **blank field** in the Applicant's response to this Schedule will be taken to be an agreement response.

Health will consider the Applicant's statement of compliance/agreement in its assessment of Applications under this ITA.

After the **Closing Time**, the Applicant must not seek to alter a clause that it has stated it complies with.

1. I/We have read, understand and agree with **Section 1 (Definitions)** of ITA DOHA 309/1112

<b>Yes</b>	<input type="checkbox"/>	<input type="checkbox"/> go to 2 below
------------	--------------------------	--

<b>No</b>	<input type="checkbox"/>	specify the extent and reasons in the table below.
-----------	--------------------------	--

**Detail the extent and reasons of non-compliance/non-agreement and details of any alternative proposal.**

**If you require additional space to fully address the requirement, copy the above box and insert before paragraph 2**

Signed by an authorised signatory or signatories of your organisation					
-----	Date	/ /	-----	Date	/ /

2. I/We have read, understand and agree with **Section 2 (Lodgement of Applications)** of **ITA DOHA 309/1112**

<b>Yes</b>		<input type="checkbox"/> <input type="checkbox"/> go to 3 below
------------	--	---

<b>No</b>		<input type="checkbox"/> specify the extent and reasons in the table below.
-----------	--	---

<b>Detail the extent and reasons of non-compliance/non-agreement and details of any alternative proposal.</b>

<b>If you require additional space to fully address the requirement, copy the above box and insert before paragraph 3</b>
---

Signed by an authorised signatory or signatories of your organisation
----- Date / /----- Date / /

3. I/We have read, understand and agree with **Section 3 (Conditions of Applications)** of **ITA DOHA 309/1112**

<b>Yes</b>		<input type="checkbox"/> <input type="checkbox"/> go to 4 below
------------	--	---

<b>No</b>		<input type="checkbox"/> specify the extent and reasons in the table below.
-----------	--	---

<b>Detail the extent and reasons of non-compliance/non-agreement and details of any alternative proposal.</b>

<b>If you require additional space to fully address the requirement, copy the above box and insert before paragraph 4</b>
---

Signed by an authorised signatory or signatories of your organisation
----- Date / /----- Date / /

4. I/We have read, understand and agree with **Section 3 (Part B: About this ITA)** of ITA DOHA 309/1112

<b>Yes</b>		<input type="checkbox"/> <input type="checkbox"/> go to 5 below
------------	--	---

<b>No</b>		<input type="checkbox"/> specify the extent and reasons in the table below.
-----------	--	---

<b>Detail the extent and reasons of non-compliance/non-agreement and details of any alternative proposal.</b>

<b>If you require additional space to fully address the requirement, copy the above box and insert before paragraph 5</b>
---

Signed by an authorised signatory or signatories of your organisation
----- Date / / ----- Date / /



5. I/We have read, understand and agree with **Section 3 (Part C: Assessment of Applications)** of **ITA DOHA 309/1112**

<b>Yes</b>		<input type="checkbox"/> <input type="checkbox"/> go to 6 below
------------	--	---

<b>No</b>		<input type="checkbox"/> specify the extent and reasons in the table below.
-----------	--	---

<b>Detail the extent and reasons of non-compliance/non-agreement and details of any alternative proposal.</b>

<b>If you require additional space to fully address the requirement, copy the above box and insert before paragraph 6</b>
---

Signed by an authorised signatory or signatories of your organisation
----- Date / /----- Date / /

6. Are there any other comments you would like to add in relation to **ITA DOHA 309/1112**?

Signed by an authorised signatory or signatories of your organisation

-----Date / /                      -----Date / /

**SCHEDULE 10 – APPLICANT’S STATUTORY DECLARATION**

**Project Name:** ITA DOHA 309/1112

*Notes to Applicants:*

- *Clauses 1 to 14 of this Declaration are not to be altered except to name consortium members in Clause 3.*
- *Personal information on this form is collected in order to assist Health with its evaluation of the Application. The information will be used only for the purpose for which it was provided and will not be disclosed except as authorised or required by law.*
- *This Statutory Declaration must be completed by an appropriate official from your organisation who has the legal authority.*

**Insert name and address of person making the declaration:**

I,	
----	--

Do solemnly and sincerely declare as follows:

<b>Authority</b> Insert position/title (for example, Proprietor, Director):	
that I am currently a	

**Insert name of Applicant:**

of	
----	--

and I am authorised to make this declaration on its behalf.

<b>Offer and Statement of Compliance</b> Insert name of Applicant:	
on behalf of	

make the following declaration under the *Statutory Declarations Act 1959*:

1. Apart from any actual or potential conflict of interest declared in Schedule 1.6 of this Application, at the date of lodging the Application, no conflict of interest exists or is likely to arise concerning the Applicant in respect of the ITA process or the Applicant’s provision of Medicare-eligible MRI services. If at any time during the ITA process, a conflict of interest arises or is likely to arise concerning itself or a related entity, the Applicant will notify Health immediately in writing of that conflict or risk of potential conflict.
3. The Applicant [and *[name any consortium members]*] warrants and undertakes that it complies (and will continue to comply) with the requirements of the ITA not to:
  - (a) engage in misleading or deceptive conduct in relation to the ITA process;
  - (b) engage in any collusive tendering, anti competitive conduct or any other similar unlawful

- (c) conduct with any other Applicant or any other person in connection with the ITA process; attempt to influence improperly any officer, employee or agent of the Health, or violate any applicable laws or Commonwealth of Australia ("**Cth**") policies regarding the offering of inducements in relation to the ITA process, and in particular, the Applicant confirms that it did not prepare the Application with the benefit of:
    - i. information obtained from a current or former officer or employee of the Commonwealth in circumstances that constitute a breach of confidentiality or fidelity on the part of that person or a breach of section 70 or 79 of the *Crimes Act 1914*, the *Criminal Code* or the *Public Service Regulations*; or
    - ii. improper assistance of employees or former employees, or contractors or former contractors, or officers or former officers of Health, Medicare Australia or any other department or agency of the Commonwealth; and
  - (d) through its officers, employees and agents, the Applicant has not attempted and will not attempt, to influence improperly any officer of the Commonwealth in connection with the assessment of this Application.
4. The Applicant is aware that giving false or misleading information is a serious offence under the *Criminal Code*. The Applicant warrants and undertakes that it has:
- (a) not made any false declarations in respect of any current or past dealings with the Commonwealth or Medicare Australia, including in any tender or Application process or in any agreement;
  - (b) had no significant deficiency in the performance of any substantive requirement or obligation under any prior agreement with the Commonwealth or Medicare Australia which would materially adversely affect the Applicant's ability to deliver the MRI services as detailed in the ITA; and
  - (c) the resources, or will be able to obtain the resources, likely to be required to provide the Medicare benefits eligible MRI service.
5. Neither the Applicant nor any of its employees, agents or contractors had knowledge of the details of the Application of any other Applicant prior to the Applicant lodging its Application for the provision of the Medicare benefits eligible. Neither the Applicant nor any of its employees, agents or contractors disclosed the details of its Application to any other Applicant or to any other person or organisation associated with another Applicant prior to the Closing Time. The Applicant is genuinely competing to provide the Medicare benefits eligible MRI service.
6. Prior to the Applicant lodging its Application neither the Applicant nor any of its employees, agents or contractors entered into any contract, agreement, arrangement or understanding that if successful, the Applicant would pay any money, or would provide any other benefit or other financial advantage, to or for the benefit of any other party who unsuccessfully responded to the ITA.
7. The Applicant warrants that it has complied with all other relevant laws in preparing and lodging its Application and taking part in the ITA process.
8. The Applicant warrants that it will not, prior to the selection of the successful Applicant, depart from the information it has provided or statements or claims it has made in its Application.
9. The Applicant hereby consents to and authorises Health, Medicare Australia and their officers, employees, agents or advisers to undertake any checks, such as confidential references and probity checks referred to in the ITA.
10. The Applicant agrees to provide at the Applicant's expense reasonable assistance to Health and Medicare Australia to assist them in any checking they wish to have undertaken under or in respect of the ITA.
11. To the best of the Applicant's knowledge after proper enquiry, the Application is accurate in every respect. The Applicant acknowledges that if the Applicant is found to have made false or misleading claims or statements, or to have used confidential information, or received improper assistance, Health may reject at any time any Application lodged by or on behalf of the Applicant.

12. The Applicant agrees:
- (a) to notify Health promptly of any change, after lodgement of its Application, to:
    - i its corporate structure;
    - ii its ownership structure; or
    - iii the basis upon which it will have access to the necessary skills, resources or corporate or financial backing to provide MRI services; and
  - (b) where such change would alter any of the information or assurances that the Applicant has given in the response to this ITA, to promptly:
    - i notify Health;
    - ii identify with specificity (including all relevant page, section, clause, schedule, exhibit and other like references to its Application, and any other material and information provided to Health), all such information and assurances; and
    - iii state in detail the alterations to such information and assurance required by such change.
13. The information provided in this statutory declaration and the Application Form (including attachments) is complete and correct and together they constitute an offer to Health on the terms set out in those documents;
14. The Applicant has completed, to the best of its ability, all parts of, and answered all of the questions on, the Application Form submitted to Health.

I confirm that:

- (a) the information provided in this form and all appended documents is complete and, to the best of my knowledge after having made proper enquiry, correct;
- (b) my organisation understands that Health will have the right (but not be obliged) to act in reliance upon the contents of my response to the Application, including its attachments, any statutory declarations and associated material;
- (c) my organisation will regard all communication with Health as confidential and not disclose their contents without Health's prior written consent; and

### **Authorisation**

Health is authorised to undertake the necessary steps to assess this Application by checking information contained within this Application with, or obtaining additional information from:

- (a) Other Australian Government agencies such as the Australian Taxation Office, Australian Securities and Investments Commission;
- (b) State or Territory agencies;
- (c) Law enforcement agencies;
- (e) Courts or Tribunals; or
- (f) Any other appropriate organisation or person reasonably required as part of these checks.

### **No Illegal Activities**

I confirm that:

- (a) the Application to which this statutory declaration is appended has not been prepared with the benefit of:
  - (i) information obtained from a current or former officer or employee of the Australian Government in circumstances that constitute a breach of an obligation of confidentiality or fidelity on the part of that person or a breach of section 70 or 79 of the *Crimes Act 1914*, the *Criminal Code* or the *Public Service Act 1999* or information otherwise improperly obtained from the Australian Government; or



## Persons before whom statutory declarations may be made

### Members of the following professions:

- Chiropractor
- Medical practitioner
- Pharmacist
- Dentist
- Nurse
- Veterinary surgeon
- Legal practitioner
- Patent Attorney
- Optometrist
- Physiotherapist
- Psychologist
- Trade marks attorney

### Other persons:

- Agent of the Australian Postal Corporation who is in charge of an office supplying postal services to the public
- Australian Consular Officer, or Australian Diplomatic Officer, (within the meaning of the *Consular Fees Act 1955*)
- Bailiff
- Bank Officer with 5 or more continuous years of service
- Building society officer with 5 or more years of continuous service
- Chief executive officer of a Commonwealth court
- Clerk of a court
- Commissioner for Affidavits
- Commissioner for Declarations
- Credit union officer with 5 or more years of continuous service
- Employee of the Australian Trade Commission who is:
  - (a) in a country or place outside Australia; and
  - (b) authorised under paragraph 3(d) of the *Consular Fees Act 1955*; and
  - (c) exercising his or her function in that place
- Employee of the Commonwealth who is:
  - (a) in a country or place outside Australia; and
  - (b) authorised under paragraph 3(d) of the *Consular Fees Act 1955*; and
  - (c) exercising his or her function in that place
- Fellow of the National Tax Accountants' Association
- Finance company officer with 5 or more years of continuous service
- Holder of a statutory office not specified in another item in this Part
- Judge of a court
- Justice of the Peace
- Magistrate

- Marriage celebrant registered under Subdivision C of Division 1 of Part IV of the *Marriage Act 1961*
- Master of a court
- Member of Chartered Secretaries Australia
- Member of the Association of Taxation and Management Accountants
- Member of the Australian Defence Force who is:
  - (a) an officer; or
  - (b) a non-commissioned officer within the meaning of the *Defence Force Discipline Act 1982* with 5 or more years of continuous service; or
  - (c) warrant officer within the meaning of that Act
- Member of the Institute of Chartered Accountants in Australia, the Australian Society of Certified Practising Accountants or the National Institute of Accountants
- Member of the Institution of Engineers, Australia, other than at the grade of student
- Member of:
  - (a) the Parliament of the Commonwealth; or
  - (b) the Parliament of a State; or
  - (c) a Territory legislature; or
  - (d) a local government authority of a State or Territory
- Minister of religion registered under Division 1 of the Part IV of the *Marriage Act 1961*
- Notary public
- Permanent employee of:
  - (a) The Commonwealth or of a Commonwealth authority; or
  - (b) a State or territory or of a State or Territory authority; or
  - (c) a local government authority; with 5 or more years of continuous service who is not specified in another item in this Part
- Permanent employee of the Australian Postal Corporation with 5 or more years of continuous service who is employed in an office supplying postal services to the public
- Person before whom a statutory declaration may be made under the law of the State or Territory in which the declaration is made
- Police officer
- Registrar, or Deputy Registrar, of a court
- Senior Executive Service employee of:
  - (a) the Commonwealth or a Commonwealth authority; or
  - (b) a State or Territory or a State or Territory authority
- Sheriff
- Sheriff's officer
- Teacher employed on a full-time basis at a school or tertiary education institution
- Member of the Australian Institute of Mining and Metallurgy

**SCHEDULE 11 – ACKNOWLEDGEMENTS**

**Project Name: ITA DOHA 309/1112**

If this Application for Medicare-Eligibility for MRI services is successful, the Applicant acknowledges and agrees:

- that a description of the initiative and name of the Applicant's organisation may be:
  - included in the Department's reporting on the internet in line with the Commonwealth Grant Guidelines and Senate Orders;
  - used by the Commonwealth in media releases and other publications (such as Annual Reports); and/or
  - used to compile a consolidated report.
- that it will be required to provide proof that it has sufficient insurance cover to conduct the proposed activities specified in this Application Form (see Schedule 1.5 - Insurance ); and
- that the provider agree to enter into and abide by the requirements of the Department's Deed of Undertaking (see ITA DOHA 309/1112 - Clause 44)

[Indicate whether the Applicant makes the above acknowledgements] YES / NO  
If NO, please explain why the Applicant has not made the above acknowledgements.

.....  
.....  
.....  
.....

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /



**SCHEDULE 12 – CONSORTIA DECLARATION**

**Project Name: ITA DOHA 309/1112**

Guidance for completing this Declaration

*This Declaration must be signed by an authorised representative of the Lead Organisation, if this Application is a joint Application. The authorised representative should be a person who is legally empowered to enter into contracts and commitments on behalf of the Applicant / Lead Organisation.*

*An Application which does not provide all required information or which contains false or misleading information may be excluded from consideration.*

As the lead agency on behalf of a Consortia:

I hereby apply for Medicare eligibility for MRI services provided under the Magnetic Resonance Imaging (MRI) Area of Need initiative of the Diagnostic Imaging Review Reforms Package 2011-12.

I certify that the information given in this Application is complete and correct.

Signature: \_\_\_\_\_

Name (BLOCK LETTERS): \_\_\_\_\_

Position of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /

**SCHEDULE 13 – APPLICANT’S CHECKLIST**

**Project Name:** ITA DOHA 309/1112

This checklist is provided to assist Applicants with a final check of their Application prior to submission. Although strongly advised to do so, there is **NO** requirement for the Applicant to complete [Schedule 13](#).

**Instructions: Tick the box reflecting your response.**

	Yes	No	N/A
1. Time spent completing the Application (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Read <b>ITA DOHA 309/1112</b> - Application	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Application has been completed, including the following:			
<a href="#">Schedule 1.1 – Applicant’s details</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule 1.2 – Contact details	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule 1.3 – Project Partners (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule 1.4 – Management Committee (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule 1.5 – Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule 1.6 – Conflict of Interest (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule 1.7 – Applicant’s Proposed Confidential Information (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule 1.8 – Attachments (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule 1.9 - Privacy and Confidentiality Notices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 2 – Specification</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 3 – Probity consents</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 4 – Essential Criteria</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 5 – Primary Assessment / Weighted Criteria</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 6 – Primary Assessment / Non Weighted Criteria</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 7 – Secondary Assessment / Weighted Criteria</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 8 – Supporting Statement</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 9 – Statement of Compliance/Agreement</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 10 – Applicant’s Statutory Declaration</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 11 – Acknowledgements</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 12 – Declaration</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="#">Schedule 13 – Applicant Checklist</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signed by an authorised signatory or signatories of your organisation

-----Date / / -----Date / /

