



# Verification of Qualifications

I, \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ acknowledge  
*(Insert Full Name and Surname and/or any previous names)* *(Insert Date of Birth)*

that the information provided by me in my RAHC Application Form is true and correct.

I hereby give permission for RAHC, through Aspen Medical, to access information and/or verify my qualifications with respect to this application.

Name of Qualification(s):	
Conferral Date(s)	
Signature:	
	Date:        /        /