RAHC
REMOTE AREA HEALTH CORPS

Verification of Qualifications

- Please enter your qualification name, the name of the tertiary institution and the year of completion in the box below.
- Please only enter relevant tertiary qualifications, including your initial qualification and any postgraduate qualifications.
- Do not list professional development (PD).
- For assistance completing this form, please contact the RAHC team on 1300 697 242 or enquiries@rahc.com.au

Your qualifications

Name of tertiary qualification *(i.e. Bachelor of Medicine, Certificate III in Dental Assisting)*	**Tertiary institution** *(i.e. University of Sydney)*	**Year of completion** *(Conferral date)*

Declaration

I, _____(full name and previous name(s) if relevant), of the address _____ (current home address) born ___/___/___ (date of birth DD/MM/YY) declare the information provided above is true and correct.

I give permission for RAHC and/or Aspen Medical to access my information with the tertiary institution(s) listed above and for the institution(s) to release any evidence or required information regarding the above listed Qualifications with respect to this application.

Your signature Date

Please return this completed form to Remote Area Health Corps via:

Mail Remote Area Health Corps. Unit 34, 2 King St, Deakin, ACT, 2600 **Email** enquiries@rahc.com.au **Fax** (02) 6203 9598

Unit 34, 2 King St, Deakin ACT 2600
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