



THE UNIVERSITY OF
NOTRE DAME
A U S T R A L I A

SCHOOL OF MEDICINE, FREMANTLE

Doctor of Medicine

**PERMISSION TO RELEASE CONTACT INFORMATION TO AUSTRALIAN MEDICAL ASSOCIATION
(WA) – AMA (WA)**

I, (full name)

Student ID No.:

Give the School of Medicine, Fremantle permission to release my contact details to Australian Medical Association (WA) – AMA (WA).

Has not been actioned

