THE UNIVERSITY OF NOTRE DAME AUSTRALIA

SCHOOL OF MEDICINE, FREMANTLE

Doctor of Medicine

PERMISSION TO RELEASE CONTACT INFORMATION AND PHOTOS TO EDUCATION PROVIDERS

I, (full name)

Student ID No.:

Give the School of Medicine, Fremantle permission to release my contact details, photo and documentation relevant to my placements to off-campus providers of my medical education, including Murdoch University, the Rural Clinical School of Western Australia, hospitals, general practices, other medical practitioners and aged care facilities.
I understand that this information will only be provided as required to people or organisations involved in providing me with teaching or other educational opportunities.

Date:

Has not been actioned