Australasian Academy for Professional Support ACN 123 994 712

APPLICATION

AAPS
AUSTRALASIAN ACADEMY FOR PROFESSIONAL SUPPORT

APPLICANT INFORMATION

First Name:	Last Name:	Title:
Date of birth:	Male ☐ Female ☐	Phone:
Current address:		City:
State:	Postcode:	Country:
Postal address (if different from above):		City:
State:	Postcode:	Country:
Mobile number:	Fax:	Email:

CONTACT DETAILS IN AUSTRALIA (IF APPLICABLE

First Name:	Last Name:	Title:
Postal address:		
City:	State:	Postcode:
Mobile number:	Fax:	Email:

ACADEMIC QUALIFICATION SUMMARY

Original qualification:	
Awarding Institution:	Date:
Postgraduate qualifications:	
Awarding Institution:	Date:
Certified copies of academic transcripts enclosed (please list):	
Have you attempted the ADC part 1 examination (theory)? Please provide details	
Have you attempted the ADC Part 2 examination (restorative and endodontics)? Please provide details	
Have you completed the ADC Part 3 examination (periodontics and oral surgery)? Please provide details	
☐ Please tick this box if you agree to the ADC releasing your results to AAPS	

MODULE DATES

Modules are available as indicated right.

1. Please circle your preferred dates.
2. Please delete any dates when it would be impossible for you to attend.
3. You may choose to indicate your first three date preferences.

Module 1	Module 2	Module 3	Module 4	Module 5

Next Clinical Practice Course starts 2 February 2009.
The dates of other courses will be annouced when available.

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BOOKING FORM

MODULE BOOKINGS

MODULE DETAILS

Please place a tick in the box for each of the modules that you wish to attend

- ☐ **Module 1:** Getting the Position (2 days $ 1500 exc. GST)
- ☐ **Module 2:** Health Practice in Australia (2 days $1500 exc. GST
- ☐ **Module 3:** Making it Work (3 days $2250 exc. GST)
- ☐ **Module 4:** Clinical Practice in Australia (5 days $3,250 exc. GST)
- ☐ **Module 5:** Living in Australia; family and partners (2 days $1000 exc. GST)

☐ I want to attend all five Modules.

For further details go to: **austacademy.com.au**.

Please indicate whether you wish to discuss ongoing professional support through our Mentoring Program.

☐ Yes, I am interested. ☐ No, I am not interested.

APPLICATION INFORMATION CONTINUED

Name of a relative not residing with you:

Address: Phone:

City: State: Postcode:

Relationship:

1. Please provide a certified copy indicating HBV, HBC and HIV status:

2. Please provide confirmation of temporary registration with Dental Board of NSW:

PAYMENT OPTIONS

PLEASE NOTE: **Payment must be received in full in advance of each module.** (TICK the appropriate boxes):

☐ I enclose a cheque or money order made payable to "AAPS".:

Please charge my Credit Card ☐ VISA ☐ Mastercard ☐ American Express ☐ Bankcard to the amount of: **$**

Cardholder's Name:

Card Number:

Signature:

Expiry date: / /

Date: / /

CHECKLIST

Please check if you have enclosed the following; (Please tick)

☐ Certified academic transcripts ☐ Certified immunisation status

☐ Copy of temporary registration with Dental Board of NSW ☐ Payment for modules

Please ensure that all of the sections of this form have been completed. Otherwise there will be a delay in processing your application.

TERMS AND CONDITION

Please TICK and SIGN ☐ I have read the Terms and Conditions and I agree (See Terms and Conditions next page)

Signature: Date: / /

Send the completed application forms with your payment for Module(s) to:

AAPS - Mr Paul Baker, Consultant –
Level 5, 345 George Street, Sydney NSW 2000

or FAX to:

02 - 9018 9900