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| ***Access to Personal Information Request Form*** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Premium Health respects the privacy and confidentiality of its personnel and clients who use our products and services.  A student / individual can access and seek correction of their personal information held by as outlined later in our privacy policy, in sections: 12APP and 13APP.  All requests for access to personal information including a certificate reprint must be in writing as the student / individual must be able to identify themselves and verify their identity prior to any information being disclosed. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Requirements for proof of identity are:   * + - Full legal name     - Date of Birth     - Serial number on I.D. given at time of enrolment such as driver’s licence, passport or birth certificate (If recorded)     - USI Number     - Student’s address at time of certificate issuance | | | | | | | | | | | Request Sections:   1. Third party release for qualification 2. Reprint of issued qualification 3. Change request for incorrect details 4. Legally changed name – requesting re-issuance of qualification with new legal name 5. Authorisation to provide verification of issued qualification | | | | | | | | | | | | | | | | |
| *Please complete the following details* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Given Name/s | | | |  | | | | | | | | | | | Date of Birth | | | | | DD / MM / YYYY | | | | | | | |
| (Family/last) Surname | | | |  | | | | | | | | | | | Gender:(circle) | | | | | M | | | F | | | X | |
| Title: (circle) | | | | Ms. | Mrs. | Mr. | | Dr. | | Other\_\_\_\_\_\_\_\_\_\_ | | | | | Mobile No | | | | |  | | | | | | | |
| Email address | | | |  | | | | | | | | | | | Alternate No | | | | |  | | | | | | | |
| Street Address | | | |  | | | | | | | | | | | | | | | | STATE | | | | P/CODE | | | |
| Email address | | | |  | | | | | | | | | | | Alternate No | | | | |  | | | | | | | |
| USI Number: Unique Student Identifier | | | | | | | | | | | |  |  |  | |  |  | |  | |  |  | | |  | |  |
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| *Please tick the appropriate box that you are making a request for and complete the required details* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***1*** | *Authority to View Documents (Commonwealth Privacy Act 1988) Third Party Release. Only complete this section if a copy of your Certificate or Statement of Attainment is to go directly to a third party: Employer/Association* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Qualification details | | Code |  | | | | Title | |  | | | | | | | | | | | | | | | | | | |
| Code |  | | | | Title | |  | | | | | | | | | | | | | | | | | | |
|  | **Third Party Release Declaration**:  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to Premium Health to release my  *(Insert full legal name)*  result and/or a copy of my Certificate/Statement of Attainment (SoA) for the purpose of  recording my Certificate/SoA/result to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Insert organisation’s name to release result/certificate/SoA)*  Email to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | Learner Signature:(*sign below*) | | | | | | | | | |
| Tick box |  | | | | | | | | | |
| Dec. Date: | | DD / MM / YYYY | | | | | | | |
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| ***2*** | *To email me a reprint of the originally issued Certificate/Statement of Attainment (SoA)* | | | | | | | | | | | | | | | | |
| Qualification details | | Code |  | | | | Title | |  | | | | | | | | |
| Code |  | | | | Title | |  | | | | | | | | |
|  | Learner Signature | |  | | | | | | | | | | Dec. Date: | DD / MM / YYYY | | | |
| Tick box |
|  | | | | | | | | | | | | | | | | | |
| ***3*** | *Complete the appropriate below fields that are incorrect in our records with the correct information.*  *Leave fields blank that are currently correct.* | | | | | | | | | | | | | | | | |
| Given Name/s | | |  | | | | | | | | | Date of Birth | | DD / MM / YYYY | | | |
| (Family/last) Surname | | |  | | | | | | | | | Gender:(circle) | | M | F | | X |
| Title: (circle) | | | Ms. | Mrs. | Mr. | | | Dr. | | | Other\_\_\_\_\_\_\_\_\_\_ | Mobile No | |  | | | |
| Email address | | |  | | | | | | | | | Alternate No | |  | | | |
| Street Address | | |  | | | | | | | | | | | STATE | | P/CODE | |
|  | I declare that all of the information above is accurate and true. Supporting evidence has been included. | | | | | Learner Signature | | | |  | | | Dec. Date: | DD / MM / YYYY | | | |
| Tick box |
|  | | | | | | | | | | | | | | | | | |
| ***4*** | *You have legally changed your name and you are requesting to have your qualification re-issued with your new legal name. State new legal name.*  *Note that upon application a processing fee of $20 will need to be paid.* | | | | | | | | | | | | | | | | |
| Qualification details | | Code |  | | | | Title | |  | | | | | | | | |
| Code |  | | | | Title | |  | | | | | | | | |
| Given Name/s | | |  | | | | | | | | | | | | | | |
| New (Family/last) Surname | | |  | | | | | | | | | | | | | | |
| Title: (circle) | | | Ms. | Mrs. | Mr. | | | Dr. | | | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
|  | I declare that all of the information above is accurate and true. Supporting evidence has been included. | | | | | Learner Signature | | | |  | | | Dec. Date: | DD / MM / YYYY | | | |
| Tick box |
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| ***5*** | *You are authorising the below specified person and/or business/organisation to request and receive verification that your issued qualification by Premium Health is genuine.*  *Note that Certificates issued since 2019 have a QR code which can be scanned to received instant verification of authenticity.* | | | | | | | | |
| Qualification details | | Code |  | | Title |  | | | |
| Date issued | DD / MM / YYYY | | Certificate Number | |  | | |
| Code |  | | Title |  | | | |
| Date issued | DD / MM / YYYY | | Certificate Number | |  | | |
| Requestor Name | | |  | | | | | | |
| Business / Organisation Name | | |  | | | | | | |
| Email Verification Result to | | |  | | | | | | |
|  | I give permission for Premium Health to authenticate my Certificate/SoA | | | Learner Signature |  | | | Dec. Date: | DD / MM / YYYY |
| Tick box |
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| *OFFICE USE ONLY* | | | | | | | | |
| Received and actioned by | |  | | | Date | \_\_\_\_ /\_\_\_\_\_/ \_\_\_\_\_\_\_\_ | | |
| Request has been correctly completed | | | Yes / No | Identity of person making request has been confirmed | | | | Yes / No |
| Section 1 | PDF copy of Student’s Certificate/Statement of Attainment has been sent to nominated third party | | | | | | Yes / No / N/A | |
| Section 2 | PDF copy of Student’s Certificate/Statement of Attainment has been sent to the Student | | | | | | Yes / No / N/A | |
| Section 3 | Correction of personal information has been made | | | | | | Yes / No / N/A | |
| Section 4 | Qualification has been re-issued with Student’s new legal name and sent | | | | | | Yes / No / N/A | |
| Fee has been paid | | | | | | Yes / No / N/A | |
| Section 5 | Qualification has been checked if authentic. Result has been provided to nominated recipient | | | | | | Yes / No / N/A | |