



### REQUEST FOR CERTIFICATE OF REGISTRATION STATUS

- A Certificate of Registration Status will ONLY be forwarded directly to another medical registering authority or college.
- The Certificate will not be forwarded to the requesting doctor or any other party.

Name: \_\_\_\_\_

MPO: \_\_\_\_\_

Please forward a Certificate of Registration Status to: **(tick as appropriate)**

the following registering authority. I understand the certificate will contain information relating to my current registration status in NSW, including details of any current proceedings, conditions, undertakings, suspensions, de-registrations or any other information relevant to an application for registration.

or

the following college. For college purposes I consent to the release of information concerning my registration in NSW, including details of any current proceedings, conditions, undertakings, suspensions, de-registrations or any other information relevant to the college.

Authority/College: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fax No: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Should the Board wish to contact you regarding your request, please provide the following contact details:

Email address: \_\_\_\_\_

Contact number: \_\_\_\_\_  
(Business Hours)

Fax: \_\_\_\_\_

**These contact details are for Board purposes only in case of queries in relation to your request, and will not be available to the public.**

I wish to make payment of \$50 by:

- Cheque       Mastercard       Visa       Money Order

Card number: \_ \_ \_ \_ \_      Expiry Date: \_ \_ / \_ \_

Name of cardholder: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please complete and return to:  
NSW Medical Board  
PO Box 104  
GLADESVILLE NSW 1675  
**OR** Fax: (02) 9879 2229

Office use only:	
Receipt no: _____	Date processed _____