



## Certificate of Postgraduate Training in Clinical Psychiatry Learning Declaration

Dear Employer

A member of your staff has applied to undertake the Certificate of Postgraduate Training in Clinical Psychiatry (the Certificate).

By developing the Certificate, the College aims to optimise patient care by developing enhanced skills to provide mental health care in our communities. It is anticipated that the core audience of the Certificate, will be general practitioners, rural generalists, and emergency medicine physicians.

In order to ensure you are aware of this activity and agree for the staff member to use de-identified patient information as part of the program, please complete and submit the below information.

If you have any questions or would like assistance please contact [certpsychhelp@ranzcp.org](mailto:certpsychhelp@ranzcp.org) or call 1800 337 448.

### EMPLOYER DETAILS (the business):

Business Name:	
----------------	--

ABN:	
------	--

### Authorised Contact Details

Title:	First Name	Last Name

Email:		Phone:	
--------	--	--------	--

### Business Address (this should be a street address not a PO Box)

Address (Line 1):			
Address (Line 2):			
City:		State:	
Postcode:		Country:	

### PARTICIPANT DETAILS (the Participant):

Participant Title:	Participant First Name	Participant Last Name	RANZCP ID:

- By submitting this form, I verify I am authorised to provide approval and the following consent:
- The business is aware the Participant is undertaking the Certificate within the workplace
- The business has a sufficient patient base for participant to complete course requirements
- The business agrees that its patients will be requested to provide their consent for de-identified information relating to their care and treatment, to be discussed and used in course modules, as required.



The Royal  
Australian &  
New Zealand  
College of  
Psychiatrists

Certificate of  
Postgraduate  
Training

in Clinical Psychiatry

The de-identified patient information provided will be permissible under the establishments Privacy Policy and by law.

Authorised Contact Signature: \_\_\_\_\_

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