Third Party Consent

I give consent to Deakin University, acting through the School of Medicine (Medical Imaging) to provide my contact details (specifically name, mobile phone number, email addresses) to potential employers, manufacturers, suppliers, associations, governing bodies, non-government and other organisations.

I understand that my information will only be provided to individuals or groups directly relating to present or future opportunities in the fields of medical imaging.

My consent is subject to the following limitations:

Please mark as appropriate

- ☐ None
- ☐ Usage (you may restrict which details are distributed):
- ☐ Expiry of consent (specify this if you wish - expiry date)

Participant details:

Full name: ***(Please print)***	
Mobile phone number:	
Email address (Deakin):	@deakin.edu.au
Email address (personal):	
Full name of Guardian (if consenting for a minor): ***(Please print)***	

Signature:

Date: