ALLIED HEALTH PROFESSIONS COUNCIL OF BRUNEI DARUSSALAM

LETTER OF CONSENT FOR VERIFICATION OF CREDENTIAL AND QUALIFICATION

To whom it may concern,

I, the undersigned, _____[1] agree that by signing this form I consent to _____[2] obtaining information pertaining to my time of study to the **Allied Health Professions Council of Brunei Darussalam**, Unit 2G3:02, Level 3, Block 2G, Jalan Ong Sum Ping, Bandar Seri Begawan BA1311, Brunei Darussalam. I understand that the verification issued will include my full legal name at the time of study, the level of degree undertaken, the full course title, the mode of attendance (i.e. full time or part time), the start date, the award date and classification achieved (if applicable).

Signature [3]:

Date:

[1] Your full name as it appears on the graduate certificate
[2] Name of the awarding university/higher learning institution & country
[3] Signature must be pen-signed