

**APPLICATION FOR RECONSIDERATION OF A DECISION**

Before completing this application, you should familiarise yourself with the **Reconsideration, Review and Appeals Process By-law**, available on the Governance page of the RACP website.

# Section 1 - Applicant details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title |  | Surname |  | Given name(s) |  |
| Home address |  |
| Postal address*if different from home* |  |
| Email address |  |
| Telephone contacts | Mobile |
|  | Work |
|  | Home |

**Section 2 - Contact details of others acting on your behalf (if required)**

**Note**: You are not required to be represented by another party but if you are, please provide their details.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title |  | Surname |  | Given name(s) |  |
| Postal address |  |
| Email address |  |
| Telephone contacts | Mobile |
|  | Work |
|  | Home |

# Section 3 - Details of the Decision you wish to have reconsidered

|  |  |
| --- | --- |
| Decision that you are asking the College toreconsider |  |
| Date of the correspondence advising you of the Decision |  |
| College Body that madethe Decision |  |

State the reason/s why reconsideration is sought. Include relevant correspondence from the College.

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

What decision do you want the College to make and why?

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

# Section 4 - Signature of the Applicant

|  |
| --- |
| / / |

This application must be received by the College within the timeframe specified in the

# Reconsideration, Review and Appeals Process By-law.

The application may be submitted by post or in person to: Chief Executive Officer

The Royal Australasian College of Physicians 145 Macquarie Street

SYDNEY NSW 2000 AUSTRALIA

OR

scanned and sent by email to the College email address, being: RACP@racp.edu.au