

AUTHORISED CONTACTS FORM

DETAILS			
ADA Member's Name:			
ADA Membership Number:			
Practice Name:			
AUTHORISED CONTACTS			
Full Name	Position Title	Contact Number	Email Address
ADA MEMBER DECLARATIONS			
<i>I authorise the above mentioned parties to contact the ADA HR Advisory Service to seek advice in relation to any and all employment relations matters concerning the Practice and its employees.</i>			
SIGNATURE			
ADA Member Signature:		Date:	