

**CONFIRMATION AND ACCEPTANCE OF
ABORIGINAL OR TORRES STRAIT ISLANDER DESCENT**

Name of Person _____ **DOB** _____

Address of Applicant _____

DECLARATION OF ABORIGINALITY

I _____ declare that I identify as being Aboriginal and/or Torres Strait Islander.

Applicants Signature _____ **Date** _____
(Parents signature & name if child is under 16 years)

I understand that the information given on this form is complete and correct and the information on this form is required for _____ only.

Confirmation and acceptance of Aboriginality or Torres Strait Islander Descent must be passed by a formal meeting of the Kambu Aboriginal and Torres Strait Islander Corporation for Health Board of Directors and signed by the Chairperson and Secretary under the Common Seal of the corporation.

Board Use Only

It is hereby confirmed the above person is of Aboriginal and/or Torres Strait Islander descent and identifies as an *Aboriginal and/or Torres Strait Islander Person and is accepted as such by the community in which he/she lives (*delete whichever is not applicable).

Resolution Number _____ **Date of Meeting** ____/____/____

Moved By _____ **Seconded By:** _____
(PRINT NAME) (PRINT NAME)

Signature: _____
(CHAIRPERSON)

Signature: _____
(SECRETARY)

Registered Office

Ipswich Clinic
27 Roderick Street
Ipswich QD 4305
Ph. (07) 3812 3843
Fax. (07) 3812 5177

Laidley Clinic
2/235 Patrick Street
Laidley QLD 4341
Ph. (07) 5465 3541
Fax. (07) 5465 3156

Goodna Clinic
13 Church Street
Goodna QLD 4300
Ph. (07) 3436 9600
Fax. (07) 3436 9696

**KAMBU HEALTH
CONFIRMATION OF ABORIGINALITY REQUEST FORM**

<i>This form is to accompany any application for confirmation of Aboriginality that are submitted to the Board of Directors</i>			
Details of Applicant			
Surname of Client		Given Names	
Telephone Numbers			Date of Birth
Gender & Ethnicity	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Australian South Sea Islander <input type="checkbox"/> Aboriginal & Torres Strait Islander <input type="checkbox"/> Aboriginal & Australian South Sea Islander <input type="checkbox"/> Torres Strait Islander & Aust South Sea Islander		Residential
			Postal (if different)
Reason for Making Application <i>(please tick the reason for making an application)</i>			
<input type="checkbox"/> Course <input type="checkbox"/> Housing <input type="checkbox"/> Housing Loan <input type="checkbox"/> Abstudy <input type="checkbox"/> School <input type="checkbox"/> Sport			
<input type="checkbox"/> Other (Please outline)			
Family Background (Grandparents, Parents, Brother, Sisters, Aunts)			
Involvement in the Community (What local Aboriginal and Torres Strait Islander Community activities have you been involved in or are you involved in, including being a member of Kambu Health and a client of the medical centre).			
Signature		Date	