



PROFESSIONAL QUALIFICATIONS CHECKLIST

RESPONSIBLE PARTY _____ Title _____

Organisation Name _____

Telephone: _____ Fax _____ Email _____

Address: _____

City _____ State _____ Postcode _____ Country _____

HIGHEST PROFESSIONAL DEGREE ATTAINED

Degree _____ Major Field _____

Year _____ Institution _____

MEMBERSHIP IN PROFESSIONAL ORGANISATION(S)

Organisation _____ Member Number _____

By signing, below, I represent and agree that:

- I am qualified to properly use any Sensory Tools products I order, and I have provided Sensory Tools with only accurate and true qualification information.
- Any Sensory Tools test products purchased under my account will be used by me and/or under my supervision.
- Any Sensory Tools test products purchased under my account will be used in accordance with all applicable legal and ethical guidelines.
- I have read and hereby apply Sensory Tools Assessment Groups Terms and Conditions to all orders for my account and will abide by the Sensory Tools Terms and Conditions (as may be modified or amended) and Qualification Criteria web pages.

I Agree _____ Date _____

**SENSORY TOOLS IS REQUIRED TO HAVE THIS INFORMATION ON FILE
BEFORE WE CAN PROCESS YOUR ORDER FOR PROFESSIONAL PRODUCTS.
FAX TO (+61) 2 4578 6115 OR EMAIL TO SALES@SENSORYTOOLS.NET**

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