This form must completed and signed by the counselling and psychological care provider, and must be submitted to the **Redress Counselling Program Team** at [redresscounselling@cyjma.qld.gov.au](mailto:redresscounselling@cyjma.qld.gov.au) prior to issuing your first invoice for payment.

# **Verification of Practitioner Form**

|  |  |
| --- | --- |
| Counselling and psychological care provider name: |  |
| Practice Name: |  |
| *ABN­­­­­­­­­­­­­­­:* |  |
| *Payment Method:* ***(EFT or Virtual Card)*** |  |
| *Terminal Merchant ID (if available) :* |  |
| *Terminal Acquirer ID (if available):* |  |
| *Bank account name:* |  |
| *BSB:* |  |
| *Account number*: |  |
| *Physical address:* |  |
| *PO Box (only if it is different to the physical address):* |  |
| *Contact person:* |  |
| *Contact number:* |  |
| *Email address:* |  |
| *Website (if applicable):* |  |

***I hereby declare that the information in this form is true and correct.***

***Signed:***

***Name (please print):***

***Practice Name:***

***Date:***