



EASTERN HEALTH ELECTIVES PROGRAM

ELECTIVES APPLICATION FORM

NOTE: This application must be accompanied with all documentation as per the checklist on page 11 of the [Elective Guidelines](#)

Student Information

Title* Given Name/s*

Surname/Family Name *

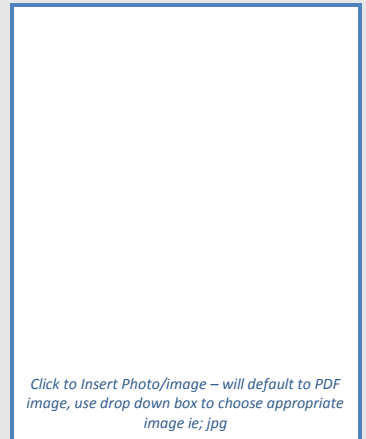
Address *

Email *

Telephone

Mobile

DOB* (dd/mm/yy)



Physical or other disabilities which may require special arrangements:

Education Information

Name of Medical School/University *

Country *

Student ID *

Years of study at time of proposed elective:

Total number of years in course:

Clinical/medical experience you will have completed prior to the proposed elective:

Elective Choices

List three (3) elective choices in order of preference. Please include start and end dates.

Note: All placements must be from a MONDAY to FRIDAY.

If you are choosing an 8 week placement would you like to have your placement split into 2 x 4 week placements between your choices below?

		Yes	No
1 st Choice Specialty:	Date From: (dd/mm/yy)	Date To: (dd/mm/yy)	Weeks
2 nd Choice Specialty:	Date From: (dd/mm/yy)	Date To: (dd/mm/yy)	Weeks
3 rd Choice Specialty:	Date From: (dd/mm/yy)	Date To: (dd/mm/yy)	Weeks

Student Applicant Signature*

Click to Insert Signature image

Date



Further Information

If contact has been made with staff at Eastern Health, please provide:

Staff Name	Contact Number	Hospital Site
<input type="text"/>	<input type="text"/>	<input type="text"/>

Vaccination Requirements

Have you been immunised against the following:	Tuberculosis (TB)		Rubella		Hepatitis B (including antibody tests to identify & follow up non-responders)	
	Yes	No	Yes	No	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**** PLEASE ATTACH WRITTEN PROOF (CERTIFIED COPIES WILL SUFFICE) OF THE ABOVE IMMUNISATIONS ****

Emergency Contact Details

Name *	Relationship to Applicant *	Contact Number *
<input type="text"/>	<input type="text"/>	<input type="text"/>
Contact Address:		Email Address:
<input type="text"/>		<input type="text"/>

Additional Details

Students are required to provide all of the following documentation with this Application Form. Please refer to your Student Guidelines or our FAQ for further information about where/how to obtain these documents.

CURRICULUM VITAE	<input type="checkbox"/>
IMMUNISATION RECORDS	<input type="checkbox"/>
NATIONAL POLICE CHECK – International Students (Obtained from www.afp.gov.au)	<input type="checkbox"/>
POLICE CHECK (must be less than 12 months old at time of Placement)	<input type="checkbox"/>
WORKING WITH CHILDREN CHECK – Australian Students Certified Copy attached (if applicable)	<input type="checkbox"/>
MEDICAL INDEMNITY INSURANCE Certified Copy attached (www.mips.com.au)	<input type="checkbox"/>

Declaration

I certify that the information I have provided on this application form is complete and accurate to the best of my knowledge. I understand that providing false or misleading information on this application form will be deemed as sufficient grounds by Medical Student Programs, Eastern Health Clinical School, as agents of Eastern Health Electives to withdraw any offer of placement and/or cancel my application.

Student Applicant Signature	Date
<div style="border: 1px solid black; height: 60px; width: 100%;"></div> <small>Click to Insert Signature image – will default to PDF image, use drop down box to choose appropriate image ie; jpg</small>	<input style="width: 100%;" type="text"/>