

APPLICATION FOR UNDERGRADUATE MEDICAL ELECTIVE



Northeast Health Wangaratta
Green St. Wangaratta
VIC. 3677

SURNAME/FAMILY NAME :		GIVEN NAMES : Preferred first name:		
DATE OF BIRTH:	FEMALE <input type="checkbox"/>	MALE <input type="checkbox"/>	OTHER <input type="checkbox"/>	
ADDRESS:		PHONE NO :		
EMAIL ADDRESS:		EMERGENCY CONTACT In case of an emergency please contact		
MEDICAL SCHOOL:	YEAR OF COURSE: (at time of elective)	Name:		
WHEN WILL YOU GRADUATE? Month _____ Year _____	CITIZENSHIP:	Relationship to you: (eg Mother, Father)	Phone number	
WHERE WILL YOU APPLY FOR A VISA?	DO YOU IDENTIFY AS ABORIGINIAL OR TORRES STRAIT ISLANDER?	Email:		
		Day	Month	Year
PROPOSED DATE OF COMMENCEMENT OF ELECTIVE	Monday			
PROPOSED DATE OF ELECTIVE COMPLETION	Friday			
Additional dates ranges if first choice is not available:				
DISCIPLINE/S TO BE UNDERTAKEN In order of preference: <u>this is a guide only</u> , as some units are more popular than others, we		What is the proposed duration of your elective? _____ Weeks		
1 st preference		1. Please state your reasons for wishing to undertake a placement at NHW 2. Please briefly outline your placement objectives and desired outcomes		
2 nd preference				
3 rd preference				
Email all documents as PDFs (list below) to: students@nhw.org.au (DO NOT SEND EXTRA DOCUMENTS UNLESS REQUESTED TO DO SO)				
<input type="checkbox"/> Application form <input type="checkbox"/> Immunisation Evidence (including TB and Fluvax evidence) <input type="checkbox"/> Passport sized photo <input type="checkbox"/> Letter of reference /good standing from your university stating you will be in your final or second last year of your medical degree at the time of your elective <input type="checkbox"/> Resume/CV <input type="checkbox"/> Proof of enrolment in your course				
DATE :		SIGNATURE:		