Before completing this application form, please ensure that you have read the guidelines and eligibility requirements.
Completed applications are to be submitted to choosecountry@ruralhealthwest.com.au

Application Form

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| --- | --- |
| First Name:  |       |
| Last Name: |       |
| Address: |       |
| Phone: |       |
| Email Address:  |       |
| University : |       |
| Discipline: |       |
| Year level: |       |
| Student ID Number: |       | Are you a member of a Student Rural Health Club?  | Yes [ ]  | No [ ]  |
| Details of Clinical Placement |
| Placement dates: |       |
| Placement location/s:Name/s of Health Service |            |
| Modified Monash Model (MMM) location:  | MMM 3  | [ ]  | MMM 5  | [ ]  | MMM 7  | [ ]  |
| MMM 4  | [ ]  | MMM 6  | [ ]  |  |
| Placement type: | Primary Health Care only | [ ]  | Hospital only | [ ]  |
| Mixed placement | [ ]  | Other | [ ]  |
| If completing a mixed placement please provide details:      |
| Intended method of travel: | Flight  | [ ]  | Self-Drive  | [ ]  | Other  | [ ]  |
| I am in receipt of any financial assistance from my university or any scholarship or bursary for this placement? If yes, please provide details.  | Yes | [ ]  | No | [ ]  |
| Have you received a grant or sponsorship from Rural Health West previously?  | Yes | [ ]  | No | [ ]  |
| Have you attached a signed letter of clinical placement from your university clinical coordinator? | Yes | [ ]  | No | [ ]  |