

Allied Health Rural Clinical Placement Support Program



Application Form

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:

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

Please specify:

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. Yes No

Have you received a grant or sponsorship from Rural Health West previously? Yes No

Have you attached proof of the clinical placement from the university? Yes No

For further information please contact choosecountry@ruralhealthwest.com.au