

SURNAME/FAMILY NAME:	
FIRST & MIDDLE NAME/S:	
PREFERRED FIRST NAME:	
GENDER:	
DATE OF BIRTH:	____/____/____
ADDRESS:	
PHONE NUMBER:	
EMAIL ADDRESS (use your University approved email only)	
MEDICAL SCHOOL NAME:	
MEDICAL SCHOOL ADDRESS:	
MEDICAL SCHOOL CONTACT:	
YEAR OF COURSE (at time of elective)	
PROPOSED DATES OF ELECTIVE:	

Email all documents listed below as PDFs to rwh-electives@unimelb.edu.au

(DO NOT SEND EXTRA DOCUMENTS UNLESS REQUESTED TO DO SO)

- Application form**
- Immunisation declaration**
- ID photo**
- Letter of good standing from your university**
(This needs to state what year level you will be in at the time you intend to do your elective)
- Resume/CV**
- Assessment form that your university requires to be signed off (if required)**

DATE: D M Y	SIGNATURE:
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