Medical Elective Authorisation Form

Student Details

Name _____

Student Number _____

Program of Study _____

Expected Graduation Date: Month _____Year_____

Mobile Phone Number _____

Email _____

Postal Address _____

_____

Suburb _____ Postcode _____

Country _____

Home Institution Details

Institution Name _____

Name of Dean (or Designate)_____

Position Title_____

Telephone_____

Email_____

Postal Address_____

_____

Suburb _____Postcode: _____

Country _____

Authorisation

This is to certify that the above student is a medical student at _____ and is of good standing. This student is currently in their ___ year of study. Upon undertaking this elective this student will be in their___ year of study.

This student is approved to complete a medical elective through The University of Queensland from

Start Date ____/_____/_____ Finish Date ____/____/____

The student has <u>successfully</u> completed the minimum of 1 semester clinical immersion as per the policy of The University of Queensland. This can be evidenced from the Academic Transcript by completion of the following course/s:

Course Code:_____   Course Name:_____

Course Code:_____   Course Name:_____

Course Code:_____   Course Name:_____

_____

Signature of Verifying Officer

_____

Position

_____

Date

University Stamp

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