

Medical Elective Authorisation Form

Student and Medical Degree Details

Student name: _____

Student Number: _____

Name of Degree the student is enrolled in: _____

Length of Degree (years): _____ Current year of study: _____

Expected Graduation Date: Month _____ Year _____

Is the medical program taught 100% in English? *(tick relevant box)* Yes ☐ No ☐

Home Institution Details

Home Institution Name: _____

Address of University: _____

Country: _____

Email: _____ Telephone: _____

Faculty Authorisation – by Dean or Delegate

Name of Dean (or Delegate): _____

Position Title: _____

I certify that the information provided in this form is true and accurate. I confirm that the above-named student is currently enrolled as a full-time student in good academic and professional standing at this university and will have completed at least 12 months of clinical experience prior to commencing the elective placement for which they are applying.

SIGNATURE OF FACULTY DEAN OR DELEGATE	UNIVERSITY SEAL/STAMP	DATE
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