Infectious Disease - Form for Period of Elective Study

Student Name: ___________________________
Student ID: ___________________________

Student Declaration:
Details of proposed elective period of study including destination, health care facilities, anticipated learning experiences and duties, departure date and duration of stay.

I have sought advice regarding potential infectious diseases and risks associated with travel and my learning/work experiences during the elective period of study

Signature: _______________________________

Health Care Provider Declaration:
The student has sought and received appropriate advice regarding potential infectious diseases and risks associated with travel and the intended learning/work experiences during the elective period of study

Name: _______________________________

Signature: _______________________________

Address or Stamp:

Date _______________________________

RETURN: Please return the signed form to the designated person within your School 4 weeks prior to the commencement of your first placement.