

MEDICAL STUDENT APPLICATION

FOR QUALITY ASSURANCE/CLINICAL AUDIT PURPOSES

Please complete **All** sections in **block CAPITALS**

***PERSONAL:***

**SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**CONTACT NUMBER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL.ADDRESS:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT DETAILS**

**CONTACT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO YOU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONTACT NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***ACADEMIC:***

**WHICH UNIVERSITY/MEDICAL SCHOOL DO YOU ATTEND?** (Include Address) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESENT YEAR OF STUDY: \_\_\_\_\_\_\_\_\_\_ YEAR & MONTH OF GRADUATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***QUALITY ASSURANCE/AUDIT DETAILS:***

**EYE AND EAR SUPERVISOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROJECT TITLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**HAS THE QA/AUDIT BEEN APPROVED BY THE EYE AND EAR HEAD OF UNIT? Yes  No**

**HAS THE QA/AUDIT BEEN ENDORSED BY THE EYE AND EAR RESEARCH OFFICE? Yes  No**

**IF YES, PLEASE STATE RESEARCH OFFICE REFERENCE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DURATION (INCLUDE START AND COMPLETION DATE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***APPLICANT’S DECLARATION:***

Declaration by Applicant

I agree to:

* keep confidential all information and data that relates to individuals involved in audit projects. I shall not make any direct copy of participants’ records;
* keep confidential any information concerning persons or events that comes to my attention at the Royal Victorian Eye and Ear Hospital. Such information includes anything relating to the audit above, and any other information which I hear, see or read during my time at the hospital;
* only use data collected for the audit for which approval has been given;
* maintain security procedures for the protection of privacy.

Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***EYE AND EAR SUPERVISOR’S AUTHORISATION:***

Supervisor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***EYE AND EAR HEAD OF UNIT’S AUTHORISATION:***

Clinic/Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head of Unit’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head of Unit’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return the completed application form with:

* a copy of your Resume or Curriculum Vitae (CV)
* a signed Eye and Ear Hospital Confidentiality Agreement
* a recent (no older than 3 months) National Police Check
* a copy of your Immunisation History Certificate (covid and influenza vaccinations are mandatory for working in clinical areas of the hospital)