



Melbourne Medical School

Melbourne Medical Elective participants are required to protect themselves and others from infectious disease transmission.

Participants will not be permitted to commence an elective placement without first meeting the hospital's minimum immunisation requirements.

Participants will need to meet all vaccination requirements at their own expense, prior to undertaking the elective, and must retain proof of any vaccinations or immunity status.

This form contains three sections

Section 1 - Participant details

Section 2 - Participant declaration

Section 3 - Immunisation status & doctor's declaration

How to ensure you protect yourself and others

- Approximately **four months prior** to your confirmed elective start date, print a copy of this form and take it to an appointment with your doctor, to discuss required vaccinations or serological testing.
- Ask your **doctor to complete section three** of this form and provide any additional information needed.
- Sign the declaration** confirming your vaccination and immunity status.
- Send a copy of this signed, completed form to your medical elective host hospital, **at least two weeks prior** to the start date.

1. Participant details

Participant name	<input type="text"/>	Date of Birth	<input type="text"/>
Country of residence	<input type="text"/>		
Melbourne hospital(s) where you are undertaking your elective	<input type="text"/>		
Elective medical specialties	<input type="text"/>		
Start date of elective	<input type="text"/>	End date of elective	<input type="text"/>
Have you attached documentary evidence? Yes / No	How many separate pages are attached?		<input type="text"/>

Medical Electives

PARTICIPANT INFORMATION

Vaccination Requirements

Protect yourself and others

medicine.unimelb.edu.au/study/clinical-electives

2. Participant declaration

Please tick each box as appropriate, and sign.

Blood borne viruses including HIV, Hepatitis C and Hepatitis B

- ☐ I declare that I have been tested for HIV, Hepatitis C and Hepatitis B within the last 12 months, and should I test positive to a blood borne virus am aware of my obligations to minimise cross infection, and receive appropriate treatment.

Tuberculosis (TB)

- ☐ I declare that I have been screened for TB in the past 12 months. If I am suffering from symptoms that may indicate that I have active pulmonary tuberculosis including cough productive of sputum, haemoptysis, fever, sweats and/or weight loss, I will seek advice from a medical practitioner to exclude this as a diagnosis prior to my elective.

- ☐ I declare that all information provided on this form and all supporting documentation is a true and accurate record of my immunisation status. I will inform my Melbourne Medical Elective hospital immediately should my immunisation status change.

Participant signature

Date

3. Immunity status & doctor's declaration

This section must be completed by a registered medical doctor.

- ☐ **Influenza**
The participant has been administered an influenza vaccine within the last 12 months.
- ☐ **Diphtheria, Pertussis, Tetanus**
The participant has been administered an adult dose of dTpa vaccine within the past 10 years.
- ☐ **Hepatitis B**
The participant has been serologically tested within the past 12 months and has been administered a full course of hepatitis B vaccine.
- ☐ **Measles**
The participant has serological evidence that indicates immunity to measles (positive IgG).
- ☐ **Mumps**
The participant has serological evidence that indicates immunity to mumps (positive IgG).
- ☐ **Poliomyelitis**
The participant has been administered a full course of poliomyelitis vaccine.
- ☐ **Rubella**
The participant has serological evidence that indicates immunity to rubella (positive IgG).
- ☐ **Varicella**
The participant has serological evidence that indicates immunity to varicella (positive IgG) or (if protective antibody levels are not demonstrated) has been administered two doses of varicella vaccine.

Doctor's declaration

I hereby declare that the above information and any attached documentation is an accurate representation of the current infection and immunisation status of the person named in section 1 of this form.

Name

Provider number (or registration number)

Practice or hospital name

Practice or hospital address

Signature

Date

Participants should submit completed forms to their Melbourne Medical Elective hospital contact.

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