

* ALL Fields are Mandatory to Complete *

EMPLOYEE DETAILS

Surname		Given Names	
Title		Date of Birth	____ / ____ / ____
Position		Health Service District	
Your Postal Address			
Your Home Address			
Home Phone Number		Mobile Phone Number	
Email Address			

SCHOLARSHIP TYPE AND DISCIPLINE (Please tick one)

<input type="checkbox"/> Rural Scholarship Scheme <input type="checkbox"/> Area of Priority Scholarship <input type="checkbox"/> Bonded Medical (Griffith) Scholarship	<input type="checkbox"/>	Dentistry	<input type="checkbox"/>	Pharmacy
	<input type="checkbox"/>	Dietetics / Nutrition	<input type="checkbox"/>	Physiotherapy
	<input type="checkbox"/>	Medicine	<input type="checkbox"/>	Podiatry
	<input type="checkbox"/>	Nursing	<input type="checkbox"/>	Psychology (Clinical Masters)
	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	Radiography
	<input type="checkbox"/>	Oral Health	<input type="checkbox"/>	Social Work
	<input type="checkbox"/>	Orthotics & Prosthetics	<input type="checkbox"/>	Speech Pathology

VARIATION DETAILS - Reason for varying your contract

<input type="checkbox"/> TRAINING	
Training Details 1	Course:
	Location:
	Dates:
Training Details 2	Course:
	Location:
	Dates:
<input type="checkbox"/> PERSONAL	
Reason <small>(e.g. Family, Medical Reasons, Reduction of Hours etc)</small>	
Supporting documentation must be attached from your GP or other health professional if indicating medical reasons.	<input type="checkbox"/> YES <input type="checkbox"/> NO

VARIATION DATES

Variation Start Date	____ / ____ / ____	Variation End Date	____ / ____ / ____
Is this an Extension of an existing variation?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
You MUST attach a COPY of your approved HR forms for any leave, movements, transfers etc.			

DECLARATION

Signature		Date	
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