

\* ALL Fields are Mandatory to Complete \*

**PERSONAL DETAILS**

<b>Surname</b>		<b>Given Names</b>	
<b>Title</b>		<b>Date of Birth</b>	____ / ____ / ____
<b>Your Postal Address</b>			
<b>Your Home Address</b>			
<b>Home Phone Number</b>		<b>Mobile Phone Number</b>	
<b>Email Address</b>			

**SCHOLARSHIP TYPE AND DISCIPLINE** (Please tick one)

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

**VARIATION DETAILS - Reason for varying your contract**

<p><b>Reason</b> (e.g. Family, Medical Reasons etc)</p> <p>Please attach additional pages if necessary.</p>	

**NB: Supporting documentation must be attached from your GP or other health professional if indicating medical reasons.**

<p><b>Will this affect your course end date?</b></p> <p>If Yes, please provide new course end date?</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO ____ / ____ / ____
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**VARIATION DATES**

<b>Variation Start Date</b>	____ / ____ / ____	<b>Variation End Date</b>	____ / ____ / ____
<b>Is this an Extension of an existing variation?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>Will you be continuing your studies during this period?</b>	<input type="checkbox"/> YES → Full-Time or Part-Time <input type="checkbox"/> NO		
<b>Do you wish to receive financial assistance for this period in return for an equivalent additional period of bonded service?</b> (Only available if continuing full-time study during this period)	<input type="checkbox"/> YES <input type="checkbox"/> NO		

**DECLARATION – (Scholarship holder to complete)**

<b>Signature</b>		<b>Date</b>	
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