

## PATIENT VOLUNTEER - EXPRESSION OF INTEREST

All details will remain confidential to the Graduate School of Medicine and will only be used to determine suitability

<b>GIVEN NAME</b>	<b>SURNAME</b>	<b>TITLE (please circle)</b>				
		<b>MR</b>	<b>MRS</b>	<b>DR</b>	<b>MS</b>	<b>MISS</b>
<b>STREET</b>						
<b>SUBURB</b>				<b>POSTCODE</b>		
<b>STATE</b>						
<b>POSTAL ADDRESS</b> (if different)						
<b>PHONE</b>	<b>(H)</b>	<b>(W)</b>	<b>(M)</b>			
<b>FAX</b>	<b>(H)</b>	<b>(W)</b>				
<b>EMAIL</b>						
<b>DATE OF BIRTH</b>						
<b>COUNTRY OF BIRTH</b>				<b>PREFERRED LANGUAGE</b>		
ABORIGINAL / TORRES STRAIT ISLANDER						
<b>SPECIAL REQUIREMENTS</b> (eg. Interpreters, Wheelchair Access, Disabilities, Transport Requirements)						
How did you hear about the programme?						
<b>AVAILABILITIES</b>						
<b>CAMPUS</b>	WOLLONGONG / SHOALHAVEN					
<b>WHEN</b>	<b>AM</b>	MON / TUES / WED / THURS / FRI / SAT / SUN				
	<b>PM</b>	MON / TUES / WED / THURS / FRI / SAT / SUN				
<b>TIMEFRAME *</b>	<b>MTHS</b>	JAN / FEB / MAR / APRIL / MAY / JUNE				
	<b>MTHS</b>	JULY / AUG / SEPT / OCT / NOV / DEC				
		ONGOING				
<small>*NB. This only needs to be an approximation</small>						
<b>Please provide a brief medical history, if applicable (ie existing illnesses or conditions)</b>						

**What attracted you to volunteering with the Graduate School of Medicine?**

**How do you think you would benefit from being a Patient Volunteer?**

**Please post back EOI to**

**Graduate School of Medicine  
Building 28,  
University of Wollongong  
NSW 2522**

or

**Graduate School of Medicine - Shoalhaven  
University of Wollongong  
PO Box 5080  
Nowra Distribution Centre NSW 2541**

**PATIENT VOLUNTEER  
OFFICE USE ONLY**

Rec. & Sel.

DATE

SIGNED

INFORMATION SESSION

Y/N

INTERVIEW

Y/N

TRAINING - PART 1

Y/N

TRAINING - PART 2

Y/N

FORM B - CODE OF CONDUCT

Y/N

FORM C - CONSENT

Y/N

COMMENTS