

DR. MEG WARREN SCHOLARSHIP FOR RURAL HEALTH



**BEECHWORTH
HEALTH SERVICE**

Please attach a
recent passport
size photo

Dr. Meg Warren Scholarship for Rural Health

APPLICATION FORM

NAME: _____

UNIVERSITY COURSE: _____

The information contained in this document is strictly confidential

DR. MEG WARREN SCHOLARSHIP FOR RURAL HEALTH

APPLICANT DETAILS

Name: _____

Home address: _____

Phone: _____ Mobile: _____

Address during semester: _____

Phone: _____

Email: _____

EDUCATION DETAILS

Secondary School/s attended: _____

COURSE DETAILS

University enrolled at: _____

Applying for entry into University at: _____

Name of Course: _____

Length of course (in full time years): _____

Have you commenced this course? No Yes **If Yes, year of study in 20** _____

Are you a full time or part time student? FULL TIME PART TIME

ADDITIONAL INFORMATION

Have you applied for, or are you in receipt of, any other grant/scholarship? Yes No

If yes, please supply details of grant (e.g. amount, name and when funding ceases).

List any rural attachments/placements you have undertaken to date:

Are you a member of the rural student's club at your University? _____

DR. MEG WARREN SCHOLARSHIP FOR RURAL HEALTH

REFEREES

Please provide the name, address and contact number for two referees, one of who must be rurally based.

| | |
|----------------|----------------|
| 1 Name: _____ | 2 Name: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| Phone: _____ | Phone: _____ |

DECLARATION

I declare that the information supplied by me in this application is true and correct on every particular.

I authorize Beechworth Health Service to seek details from the tertiary institution at which I am enrolled, including details of enrolment variations, academic record, examination results, attendance and any other matter pertaining to my eligibility to apply for the Dr Meg Warren Scholarship for Rural Health.

Signature of applicant: _____ Date: _____

Signature of witness: _____ Date: _____

Name of witness: _____

Address: _____

Please forward the completed application criteria in the following order:

Application form with attached recent passport photo

500-word essay outlining demonstrating why you wish to practice in rural Victoria including

- 1) A brief description of the applicant's proposed course of study including the nature of the course i.e. undergraduate / post graduate.
- 2) A description of how your proposed course of study will make the greatest contribution to health services locally.
- 3) Demonstration of a clear congruence between the proposed course of study and the present or future objects of rural health in Victoria

Curriculum Vitae

Current University examination results

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I acknowledge that there is a requirement to return the Scholarship if you do not undertake the proposed course of study and/or seek approval from the Selection Panel to vary your proposed course of study.

I acknowledge that there is a requirement complete the proposed course of study in the calendar year following the award of the Scholarship.

I acknowledged that by accepting the Scholarship that it may be included in the Beechworth Health Service publications.

Please attach any additional relevant information that you would like the Selection Panel to consider as part of your application.

Send your application to:

Chief Executive Officer
Beechworth Health Service
PO Box 20
Beechworth Vic 3747
info@beechworthhealth.org.au

The closing date for Applications is the last business day in November of each year.