VICTORIAN
RURAL GENERALIST
PROGRAM

CONSENT FORM

I, ……..*<first and last name>*, am the partner of doctor, …….. *<doctor's first and last name>*, enrolling in the Victorian Rural Generalist Program.

My partner, Doctor <insert name> and I, have requested support from the VRGP regarding our social, or community, or education, or training, or employment or disability support needs during the placement.

I consent to the Department of Health, Victoria (and to its funded organisations or contractors) collecting, using and storing our personal information (listed below) for the purpose of receiving the above-mentioned support.

Information requested	**Partners Personal information**	
First name		
Last name		
Email address		
Mobile number/Telephone number		
I live in rural or regional Victoria		
I will be moving to live in rural or regional Victoria		
I identify as Aboriginal or Torres Strait Islander		
I or my parents were born in Australia		
I speak a language other than English at home		
I have a culturally diverse background other than that indicated in the previous questions		
I identify as a person with a disability		
I would like employment, social, community, sporting and recreation, disability support, further education or training assistance in moving to a rural or regional community. *(Please tick the box aligning to your support request(s))*	Employment ☐	Social ☐
	Sporting & Recreation☐	Disability support☐
	Education & Training ☐	
	Other:	

Partner name: _____

Partner signature: _____

Dated: _____

Witness (other than doctor partner): _____ (signature)

Witness name: _____

Child's or Dependant's personal information

I/We consent to the Department of Health, Victoria, or its funded organisations or contractors collecting personal and health information about my child(ren) or other dependant(s) for the purposes of obtaining support from the VRGP during the term of the placement.

Information requested	Child's or Dependant's personal information	
First name		
Last name		
Date of birth and age	D.O.B:	
	Age in years:	
Gender or Sex		
Do you have a Power of Attorney or Guardianship Order for this child/dependant?		
	Power of Attorney ☐	Guardianship Order ☐
Early learning, kindergarten or childcare needs		
Schooling and year level need(s)		
Support for developmental or learning delays?		
Our child/dependant identifies as a person with a disability		
Special schooling need(s) and level of support		

**Repeat table for each child or dependant*

Partner's - First and Last Name		**Doctor's - First and Last Name:**	
Relationship to Child or Dependant		**Relationship to Child or Dependant**	
Signature		**Signature**	
Date	____ / ____ / _____	**Date**	____ / ____ / _____

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