



THE UNIVERSITY OF  
**NOTRE DAME**  
A U S T R A L I A

**SCHOOL OF MEDICINE, FREMANTLE**

*Doctor of Medicine*

**Student Declaration Form Infectious Diseases Policy**

I, (full name)

Student ID

I declare that I have read, understood and agree to comply with the School of Medicine, Fremantle's Infection Diseases Policy for the duration of the Doctor of Medicine program.

I understand my responsibilities to protect myself as an individual and my responsibility to protect patients from the hazards of blood borne and other infectious diseases.

I have undertaken the testing and immunisation requirements required by the School of Medicine, Fremantle for enrolling students and submitted the completed and signed *Immunisation Pack for Commencing Medical Students*.

I am aware of my infectious status for blood borne viruses.

I agree that if I test positive for a blood borne virus such as Hepatitis B, Hepatitis C or HIV that I will exclude myself from exposure prone procedures and that I will seek counselling from the Dean of Medicine, Fremantle about the implications for clinical practice and future career options

Date (dd/mm/yyyy)

Has not been actioned

