



THE UNIVERSITY OF  
MELBOURNE

Faculty of Medicine, Dentistry and Health Sciences  
**VARIATION TO CANDIDATURE FORM**  
**RESEARCH HIGHER DEGREES**

- Advice is available by contacting the Research Higher Degrees Officer on 903 58068 or email: j.bacon@unimelb.edu.au
- Students should ensure that they complete all relevant details of their request, and **should then pass it to their supervisor(s)**. When the 'Supervisor & Head of Department's Recommendation' is complete, this form should be forwarded to the Research Higher Degrees Officer, MDHS Student Centre, Ground Floor, Medical Building, (or via fax 9347 7084) for assessment by the Associate Dean (Research Training).

**Personal Details**

Name: \_\_\_\_\_ Student No.: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Daytime Telephone No. or Email Address: \_\_\_\_\_

Course: \_\_\_\_\_ Department: \_\_\_\_\_

Supervisor(s): \_\_\_\_\_

**Request for:**

*Please tick the relevant box(es)*

- |   |   |                                    |   |
|---|---|------------------------------------|---|
| <input type="checkbox"/> Full Time to Part Time | <input type="checkbox"/> Change of Thesis Title | <input type="checkbox"/> Extension | <input type="checkbox"/> Discontinuation  |
| <input type="checkbox"/> Part Time to Full Time | <input type="checkbox"/> Change of Supervisor   | <input type="checkbox"/> Lapse     | <input type="checkbox"/> Leave of Absence |

**Details**

Please state your request clearly and provide reasons. Please include all relevant details such as the dates for leave of absence or period of extension requested (eg 6 months) or any other important information. (Attach page if additional space is required).

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Supervisor(s) Recommendation**

Request supported? **YES / NO** Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor(s) comments: \_\_\_\_\_  
\_\_\_\_\_

**Head of Department's Recommendation**

Request supported? **YES / NO** Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Faculty Approval**

Request for: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Dean or Associate Dean (Research Training), Faculty of Medicine, Dentistry and Health Sciences*