

Policy Document

Clinical Placements and

Remunerated Medical Student

Positions (2026)

Executive Summary

AMSA believes that clinical placements are an essential component of quality medical education and should facilitate the development of clinical knowledge that provides the necessary preparation for competent medical practice.

AMSA further believes that mandatory, unpaid clinical placements impose significant burdens for medical students, contributing to placement poverty. Australian medical students typically complete over 2000 hours of intensive clinical placement, with strict attendance requirements and limited control over location. Medical students incur substantial indirect costs for transportation, accommodation, required equipment, and reduced time to work part-time due to the demands of clinical placement. Psychological burdens and mental health challenges are also common for medical students undergoing clinical placements. Financial stress and social isolation due to rural location can further exacerbate such psychological burdens. These burdens disproportionately impact students from disadvantaged groups, including First Nations, rural or remote, low socioeconomic status, mature-aged, LGBTQIASB+, students with disabilities, and carer students; which is perpetuating inequities and raising attrition risks as students prioritise paid work or discontinue studies. AMSA therefore believes that recognition of this disproportionate burden must be accompanied by structural responses within placement systems, including culturally safe supervision, protected reporting pathways, and accountability mechanisms that support equity in clinical training. AMSA also supports clear expectations for supervision and learning environments that are safe for First Nations students and other students experiencing structural marginalisation.

AMSA strongly advocates that paid medical clinical placements are needed to end placement poverty. Specifically, AMSA urges all relevant parties, including the Australian Medical Council, Australian Medical Education Providers (MEPs), and Hospital and Health Services involved in the provision of placement, to support advocacy for remunerated clinical placements through the extension of Commonwealth Prac Payment (CPP) to medical students. While medical students currently have the opportunity to receive remuneration from NSW Health or Queensland Health as Assistants in Medicine (AiM) or Students in Medicine (SiM), AMSA believes that these limited, selective, and potentially temporary opportunities fail to equitably address placement burdens. The CPP



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represents a means-tested and more equitable model of financial support for mandatory clinical placements. The expansion of CPP to include medical students should be reflected in legislative review of the CPP scheduled for 2027-2028, if not sooner.

In light of the CPP being expanded to medical students there is much needed review and research in order to characterise the components of quality clinical placement that provides tangible graduate skills, competencies, and outcomes. Research and correlation between placement activities and outcomes must be conducted at all levels from MEPs through to the state and federal governments. AMSA believes that Australian medical clinical placements require expansion in the domain of fidelity to the graduate jobs, support for alleviating the burden on students, and ensuring that clinical placement learning is reflective of a clinical culture that is culturally safe, diverse, inclusive, and without prejudice.

Overall, AMSA believes that all medical students must have access to high-quality clinical placements that prepare them for competent medical practice. Expanding the means-tested CPP to include medical students would address placement poverty, reduce financial barriers, and support equitable participation in clinical training, ensuring all medical students can fully engage in clinical placements in preparation to become future doctors.

Disclaimer: AMSA acknowledges the diversity of the personal circumstances of medical students, and the challenges faced in defining 'disadvantage'. This policy is written to represent all medical students, but particularly highlights population groups that are evidently disadvantaged within the medical student body.



Policy Points

AMSA calls upon:

1. All stakeholders to:

- a. Support advocacy for the extension of the CPP scheme to Australian medical students;
- b. Respect the role of medical students on clinical placement as protected learners; and
- c. Recognise the compounded burden of clinical placement experienced by First Nations students, and students from other marginalised groups.

2. Australian Medical Education Providers to:

- a. Prioritise the provision of quality clinical placement;
- b. Develop pre-clinical and clinical curriculums that centres on both competency related to work of a junior doctor, and the learning required for eventual specialisation;
- c. Ensure all clinical teaching and resources are culturally safe, inclusive, and free from marginalisation and prejudice, by utilising:
 - i. Anti-racism informed teaching practices;
 - ii. Culturally safe supervision;
 - iii. Clear accountability for harmful behaviour; and
 - iv. Safe mechanisms for student reporting.
- d. Develop comprehensive policies for the management of social and emotional wellbeing, safety, moral injury, exhaustion, racism, discrimination, and financial burden caused by clinical placements;
- e. Ensure students facing financial burden during clinical placement are engaged with support services;
- f. Develop strong, confidential, culturally safe, and protected reporting systems to address bullying, harassment, discrimination, racism, and unsafe supervision on clinical placement, which do not rely solely on reporting to immediate hierarchies;
- g. Increase the flexibility of required clinical placement hours where appropriate;
- h. Provide students with a wide breadth of learning opportunities, through exposure to a variety of:
 - i. Specialties and subspecialties;
 - ii. Tertiary hospital centres and rural placements; and
 - iii. Hospital and community-based placements.
- i. Negotiate Student Placement Agreements to include explicit minimum supervision expectations, protected teaching provisions, and further quality indicators; and
- j. Initiate early training of medical students as future clinical educators.

3. Australian Clinical Sites to:

- a. Establish clear protocols for medical student's scope of practice and expected participation;

- b. Provide designated, protected time for all clinical activities, including teaching time and patient contact;
- c. Ensure clinician-to-student ratios support individualised learning and meaningful clinical participation;
- d. Invest in a campaign to educate patients on the benefits of student participation in their healthcare;
- e. Ensure clinical learning environments are culturally safe, particularly for First Nations students, with appropriate cultural safety training for clinical teachers;
- f. Provide standardised training for clinical teachers across their key roles (educator, role model, facilitator, assessor, and curriculum contributor), supported by incentives and involvement of clinicians teaching within their areas of expertise;
- g. Streamline occupational health and safety requirements to reduce barriers for interstate, rural, remote, and international students;
- h. Ensure students have clear, protected, and culturally safe escalation pathways, and support, for bullying, harassment, discrimination, racism, unsafe supervision, and isolation; and
- i. Support students in receiving appropriate bystander and first-responder training.

4. The Australian Medical Council to:

- a. Research and identify the parameters that define quality clinical placements, including their correlation with junior doctor competency and medical student experience;
- b. Provide comprehensive guidelines to MEPs on requirements for equitable and culturally safe placement;
- c. Develop nationally defined minimum quality and supervision indicators;
- d. Conduct audits across MEPs and Clinical Sites to determine conformance with defined standards;
- e. Set standards for MEPs for the inclusion of relevant parameters for clinical placement including:
 - i. Adequate instruction and exposure to specific health populations, including but not limited to: First Nations, LGBTQIASB+, refugees, and immigrants;
 - ii. Minimum exposures to areas of practice, presentations, and procedures; and
 - iii. Culturally safe and inclusive environments for First Nations students and patients.

5. Federal, State, and Territory Governments to:

- a. Expand the current CPP scheme to the medical students undertaking mandatory clinical placement, on a means-tested basis;
- b. Prioritise application of the CPP scheme to students from disadvantaged groups, including but not limited to:
 - i. Students with financial needs;
 - ii. First Nations students; and

- iii. Students from or undertaking placements in rural and regional areas.
- c. Research and publish information related to the efficacy, sustainability, and outcomes of students utilising the CPP scheme;
- d. Ensure current AiM or SiM programs:
 - i. Do not compromise the duration or quality of clinical placement;
 - ii. Have clearly defined tasks that align with an appropriate scope of practice;
 - iii. Act as an adjunct to the existing roles undertaken by interns and junior doctors, as opposed to a replacement;
 - iv. Include an employment contract with access to indemnity insurance and full workplace protections;
 - v. Involve clearly defined escalation and support pathways; and
 - vi. Incorporate proactive mental health support structures in line with the policy points outlined in the 'Mental Health and Wellbeing (2025)' policy.

6. Australian Medical Students to:

- a. Provide high quality, constructive feedback to highlight areas of weakness and guide ongoing improvement of clinical placement.



Background

MEDICAL STUDENT CLINICAL PLACEMENTS

Purpose of Clinical Placements.

Clinical placements are valuable opportunities for medical students to gain real-life experience, translate theoretical learning to practice, and increase career readiness. Placements are a mandatory component of all medical education, with students required to complete specified placement hours and rotations in order to graduate.[1]

Burden of Clinical Placements.

Medical students face a multitude of financial, psychological, and social burdens during clinical placements. Currently, clinical placements are mandatory, not remunerated, and involve intensive time commitment - typically a total of 2310 hours.[2] Indirect and hidden costs are often incurred to cover placement-related expenses such as transportation, food, rent, and uniforms. Concurrently, there is an opportunity cost of losing part-time work hours during placements. These costs accumulate, increasing the cost of living, and leads to placement poverty that exacerbates existing financial stress.[3] More than 70% of Australian healthcare students experience food insecurity during clinical placements,[2] with students skipping meals,[4] or taking on additional paid work to cover basic living costs.[5] The financial challenges of clinical placements disproportionately affect disadvantaged population groups.[6-8] Financial challenges can cause students to prioritise paid work, threatening interruption or discontinuation of medical studies.[9] First Nations' students specifically experience disproportionate financial, structural, and cultural burdens during clinical placement requiring structural recommendations beyond recognition alone. Thus, placement poverty perpetuates privilege, widens socioeconomic inequities, and hinders cohort diversity.[10]

Psychological stress and decreased personal wellbeing are well-studied downstream consequences of placement poverty across healthcare students.[2, 11] Financial concerns are a significant risk factor for higher levels of fatigue, anxiety, and depression,[12-14] and increases risk of impaired mental wellbeing threefold [15]; which can have flow-on negative effects on academic performance.[16] Medical students are prone to moral injury from exposure to emotionally distressing situations, unprofessional behaviours, and external pressures to perform outside of their scope.[17] Such incidents generate feelings of guilt, shame, and helplessness, of which many students are not equipped to cope with[18,19]; especially when clinical placements diminish key protective factors such as social and support networks.[6] Hence, training in cultural safety, anti-racism, and responding to student concerns can aid in improving student welfare and the overall inclusivity of clinical supervision and teaching.

Ultimately, the laborious, inflexible and demanding nature of medical placements engenders placement poverty. The students who are most affected are those underrepresented in the current medical workforce and those with interest in

medical careers outside of metropolitan cities. Rural placements, which are designed to encourage students to pursue rural employment, are hindered by a lack of support for students to relocate, survive financially, and sustain mental wellbeing, with 26% of medical students in such areas already reporting burnout.[20] Ultimately, unpaid clinical placements have adverse effects on students' individual mental health and academic performance, alongside broader effects on student attrition rates and future workforce diversity.

CURRENT OPPORTUNITIES FOR REMUNERATION AS MEDICAL STUDENTS IN AUSTRALIA

Roles and Remuneration of AiM and SiM.

Currently, final year medical students have the opportunity to be employed part-time as an Assistant in Medicine (AiM) under NSW Health,[21,22] or casually as a Student in Medicine (SiM) under Queensland Health.[23] These remunerated positions are separate from medical school clinical placements, and are based on a similar model to the Assistant in Nursing (AiN) position. In terms of remuneration, AiMs are paid at 75% of the NSW Medical Officer Intern salary,[22] while SiMs are paid at 80% of a Queensland Intern Level 1.[23]

The roles of AiMs and SiMs include many of the interns' duties, and are more clinically oriented compared to the scopes of clinical placements. Duties include clinician support services such as scribing, preparing documentation and discharge letters, and performing medical procedures under the instruction and supervision of medical specialists.[23-25] The Victorian government has also supported a recommendation to introduce a new remunerated AiM role in public hospitals for final-year medical students.[26]

Concerns for Equity on AiM and SiM.

These employment schemes offer opportunities for the selected students that are less frequently available during the mandatory clinical placements.[27] Students from these programs report enhanced clinical skills and better preparation for internships.[28] This significant advantage, both educationally and financially, calls into question the importance of an equitable selection process. There is no public information regarding SiMs in Queensland, but in NSW students register their interest in the AiM role, and then the MEPs nominate students to be considered, based on a merit system.[27] Overall, only a limited number of students will be selected for employment.[27] The selectivity of these roles are geared towards employing students from privileged backgrounds, who have the support to exceed the academic entry requirements, and take on this form of additional employment. These schemes are perpetuating cycles of privilege, and further entrenching socioeconomic gaps in medical training.

Concerns for the Sustainability of Funding for AiM and SiM.

The proposal to include AiMs and SiMs as paid employees arose during the COVID-19 pandemic, as a way to bolster staffing ratios.[21,24] According to NSW Health's AiM Evaluation Report, whilst the role was effective for its intended purpose, there is currently no identified funding source nor an ongoing need for the role within the current medical workforce structure.[21] If AiMs or SiMs are to be discontinued, redirection of funds to include medical students in the CPP will be a more equitable and long-term alternative model for remuneration for medical students.

COMMONWEALTH PRAC PAYMENT

The Commonwealth Prac Payment (CPP) is a grant funded by the Australian Government, providing \$338.60 per week to eligible students undertaking mandatory placements in nursing, teaching, midwifery, or social work,[29] to reduce the financial hardship pressures that prevent study completion.[30] Notably, medical students and allied health students are precluded from this scheme, despite having intensive, mandatory clinical placements. The selectivity of this scheme is purportedly justified as a means to address 'workforce shortages' and support the 'key enablers for the Australian economy'.[30] A much needed review of the effectiveness and expansion of the CPP is not scheduled until 2027-2028.[31] Please refer to the For More Information section for additional resources addressing the eligibility and enactment of the CPP.

GLOBAL MODELS OF REMUNERATED MEDICAL STUDENT CLINICAL PLACEMENT

The final year of the medical course in New Zealand sees students assuming a trainee intern role, with responsibilities of up to one-third of the patient load.[32,33] An annual stipend of NZD\$26756 is paid to domestic final year students by the Tertiary Education Commission of New Zealand.[34] As the intern year is under the universities' jurisdiction, education is prioritised and not compromised by service obligations.[33] In France, the second of three stages of the medical course consists of a combination of theoretical learning and internships, with students receiving an average salary of around 2,000 euros per month.[35] Similarly, the National Health Service (NHS) England piloted the now discontinued Medical Doctor Degree Apprenticeship (MDDA) in 2024 and 2025.[36] The MDDA was designed so that students undertake remunerated apprenticeships while completing a fully subsidised medical course.[37] The program offered non-clinical roles during vacation times to minimise the disruption to student's education.[38] The apprenticeship model was criticised for failing to address the complexities of widening participation, with potential solutions including additional bursaries and long-standing scholarships.[39] Switzerland MEPs have maintained remunerated medical student positions with students following daily 'shifts'.[40] A clear precedent exists for Australia to consider remuneration for clinical placements, and support Australian medical students in the same way that other countries support their future workforce.

QUALITY OF CLINICAL PLACEMENTS

Quality Clinical Placements.

Despite the centrality of clinical placement in medical education, a growing body of evidence suggests that many medical students feel their placements do not adequately prepare them for the realities of junior doctor work.[41,42] This gap is most pronounced in experiential domains, including ward-based workflows, after-hours and on-call duties, acute clinical management, prescribing, clinical prioritisation, time management, and administrative tasks.[43] Concerningly, clinical-based sign-off assessment shows little to no correlation with written exam performance, and there are no studies correlating achievement on clinical placement with competency as a junior doctor, bringing into question the utility of clinical placement altogether.[44] The Australian Medical Council (AMC) provides no public guidance regarding the structure of clinical placements or what practical experiential learning medical students must achieve during the clinical years. In 2023, AHPRA released an information paper collating recommendations of health-related placements across all domains; the recommendations fit broadly into two categories: high fidelity and high care.[45]

Quality placements enable students to engage authentically in clinical environments, which enhances intern readiness by promoting competency in the role and responsibilities of the job.[46,47] There is evidence that students benefit most from longitudinal placements, where students are fully integrated into a care team for a prolonged period.[45,46] Furthermore, students who are required to assume a level of genuine responsibility are motivated to learn beyond the expected curriculum.[48] The benefit of increased responsibility is evident in US-based medical education systems where clinical placements function as early job-interviews for medical students to obtain places into specialty programs, therefore requiring them to gain more proficiency in their chosen area before graduation.[49] Finally, a focus on the number of placement hours ignores the quality of experiences within that time. An approach focusing on the quality of learning could potentially decrease hours required, improving wellbeing for students and potentially lowering cost for institutions.[45]

Medical student clinical placement should reflect the type of workplace attitudes that students will practice once they are practitioners. Firstly, good clinical supervision is integral to quality clinical placement. Clinical supervision relies on upskilled clinicians, adequate time for a relationship to form between mentor and mentee, and a “student-centred” approach.[45,50] Clinical placement should involve the modelling of, and participating in, culturally safe practice with all prospective Australian doctors developing competency in the provision of healthcare for Australia’s First Nations peoples.[51,52] Culturally safe practice should include anti-racism, respectful supervision, accountability for harmful behaviour, and systems that support students to raise concerns safely, and ensures all medical students are protected learners with access to quality teaching.

Clinical placement should also reflect inclusive teaching practices as nearly half of students who identify within the LGBTQIASB+ community report mistreatment on clinical placement.[53] Furthermore, modelling of inclusive practices is essential in not undoing pre-clinical education on the treatment of patients from

minority groups.[54] Safety concerns for students should be managed appropriately via both clinical sites and MEPs so that students can make use of all avenues to report bullying, harassment, and exposure to moral injury on placement.

Barriers to Quality Clinical Placements.

Beyond meeting national regulatory standards, placements actively support medical education by allowing the application of theoretical knowledge within healthcare settings, practising core clinical skills and fostering the development of a professional identity and collegial relationships.[1] Furthermore, research shows that exposure to a variety of clinical environments, particularly rural placement exposure, increases the likelihood of graduates choosing rural and remote practice. However, repeated transition between vastly different healthcare environments risks the quality and continuity of clinical placement.[45]

Inequities between medical students are exacerbated by the structure of placements within MEPs and/or health systems. Placement hours and attendance policies are determined at the discretion of MEPs, resulting in program variability, limited flexibility, and increased pressure on students who may need to work outside clinical hours, often exacerbating fatigue and undermining academic performance.[55,56]

Workforce distribution shapes placement quality and access. Although Australia has increased the full-time equivalent (FTE) medical workforce by 53.1%, geographic and speciality-wise inequity has not been resolved.[57,58] Very remote areas have a reported 205 FTE medical practitioners per 100 000 population, compared to major cities with 427 per 100 000.[57] This inequitable distribution limits the availability of clinicians able to supervise medical students in rural and remote settings. As a result, students in these areas may receive fewer or lower-quality learning opportunities. These structural differences likely contribute to workforce maldistribution, with 61.5% of medical students in 2022 nominating major cities as their preferred future practice location and far fewer indicating intentions to work in regional, rural, or remote areas.[57] Additionally, inconsistent communication and variable student preparation can further strain rural placement capacity and engagement.[59] James Cook University (JCU) places an emphasis on providing accommodation, and a program structure that facilitates active collaboration between the MEPs and clinicians, however, this is not universal.[60]

There is limited research on barriers affecting international, lower socioeconomic status (SES) and First Nations students. In New South Wales, international students are generally unable to access concession cards without particular scholarships, increasing transport costs in addition to other occupational health and safety costs such as NSW Health Compliance requirements, exacerbating existing financial strain.[61,62] Structural marginalisation within health curricula, gaps in faculties' cultural training, and ongoing financial barriers disproportionately disadvantage these students. This is exemplified by First

Nations students being twice as likely to experience or witness racism; yet many students remain silent due to fears of further marginalisation.[63] This demonstrates the need for nationally-defined minimum quality and supervision indicators, encompassing protected reporting pathways, culturally safe supervisory practices, and stronger accountability mechanisms within clinical placement systems.

Clinical placements remain essential for medical education, but are inflexible. Policymakers and MEPs must redesign structures to improve flexibility, strengthen financial and institutional support, incentivise clinical educators, and create culturally safe learning environments to ensure equitable and sustainable clinical education.

Quality Assurance of Clinical Placements.

Current Accountability Structure

Under the AMC's accreditation procedures, medical courses undergo comprehensive assessments at least every ten years with structured monitoring submissions between cycles.[64] Accreditation applies to the MEPs, with site-specific issues reviewed indirectly through reporting processes.[64] Clinical placements are governed by Student Placement Agreements (SPAs) between MEPs and Public Health Organisations (PHOs). Standard 5 of the AMC's "Assessment and Accreditation Standards for Primary Medical Programs" assigns MEPs with the responsibility of providing high-quality clinical placements.[65] Sections 5.4 and 5.5 emphasise that MEPs support quality clinical learning through effective systems of supervision, provision of adequate facilities, and cooperation with clinical sites.[65] Whilst MEPs retain responsibility for student oversight, the nature and extent of supervision is cooperatively-determined.[66] Under the SPA, the PHO is responsible for providing access to facilities, patients and other elements required for clinical placement.[66] However, the SPA is not required to specify the minimum supervision standards, protected teaching time, digital access requirements, or culturally safe reporting protections, leaving key determinants of placement quality largely at the discretion of the clinical sites.

Structural Limitations and Risks

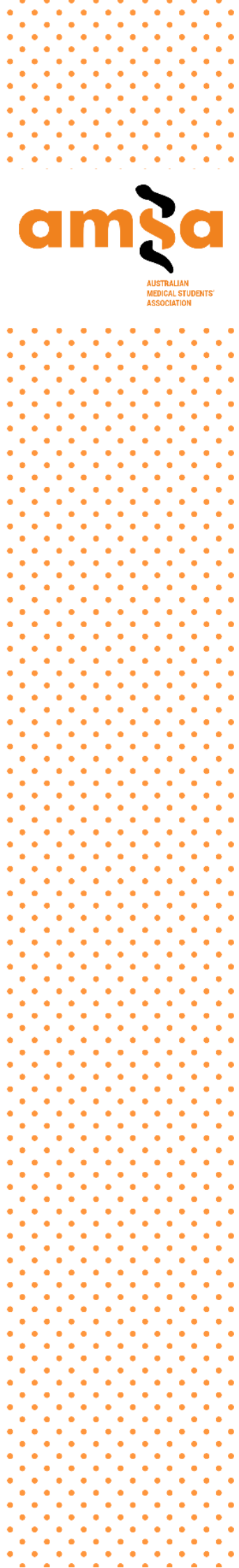
The current framework has a structural asymmetry in accountability, with MEPs responsible for demonstrating placement quality, but clinical sites controlling the quality determinants.[66] In contrast, Australia's post-graduate prevocational training operates under nationally standardised requirements that include site-level accreditation, defined supervisor roles, and documented performance reviews.[67] Health services must meet explicit standards to maintain accreditation as a training provider, aligning accountability with operational control.[67]

Clinical placement quality remains largely governance-based and resource-contingent, rather than benchmark-driven.[66] The absence of specific measurable standards has been recognised for over a decade; the National Clinical Training Review (2008) highlighted the lack of defined supervision

requirements, teaching time expectations, and supervisor–student ratios across clinical placements.

AMC accreditation reports acknowledge that MEPs cannot compel clinical staff to provide adequate supervision, highlighting the limits of current SPAs.[68] A review of final-year JCU medical students identified supervision quality, autonomy, and workload balance as key determinants of placement quality, with students reporting that locum clinicians often prioritised service delivery over teaching, in the absence of protected time.[69]

These structural gaps result in inconsistent supervision, fluctuating teaching capacity, inequitable training quality, and variable student safety across clinical sites. These gaps are most prominent in clinical sites with minimal to absent culturally safe supervision, reporting protections and accountability mechanisms. Without defined benchmarks, deficiencies are often identified only through complaints, resulting in reactive quality assurance. Further research is necessary to define and integrate these standardised benchmarks into accreditation standards and SPAs. Establishing nationally consistent benchmarks would reduce variability in placement quality and promote equity in clinical education.



For More Information

The Department of Education has publicly available information regarding the Commonwealth Prac Payment eligibility criteria, reporting requirements, and other resources available:

Commonwealth prac payment for students. Department of Education, Australian Government. 2025. Accessed February 21, 2026.

<https://www.education.gov.au/commonwealth-prac-payment-cpp/students>

The Australian Broadcasting Corporation reports on anecdotal, lived experience on students struggling through placement poverty. This article also highlights the nature of financial disadvantage for members of the LGBTQIASB+ community.

Basker R. What it's like to navigate the rental crisis as a full-time medical student. ABC News. June 05, 2023. Accessed February 20, 2026.

<https://www.abc.net.au/news/2023-06-05/cost-of-living-rental-crisis-medical-student/102414980>

The Australian Journal of Indigenous Education published a comprehensive paper evaluating barriers to graduation for Aboriginal and Torres Strait Islander students.

Ellender I, Drysdale M, Chesters J, Faulkner S, Kelly H, Turnbull L. When a dream becomes a nightmare: why do Indigenous Australian medical students withdraw from their courses?. *Aust J Indigenous Educ.* 2008 Jan;37(1):40-47. doi:10.1017/S1326011100016070

The Australian Medical Council (AMC) published a policy pertaining to the assessment on how well AMC standards were applied to clinical placements, also highlighting changes made to create a more fair experience for students with disability.

Clinical placements in undergraduate medical education: applying AMC standards to the assessment of clinical teaching placements. Medical School Accreditation Committee, Australian Medical Council. November, 2007. Accessed April 19, 2026.

https://www.amc.org.au/wp-content/uploads/accreditation_recognition/primary-medical-education/policies/AMC-Policy-Paper-Clinical-Placements.pdf



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Policy Details:

Name: Clinical Placements and Remunerated Medical Student Positions

Category: B - Medical Education

History: Reviewed, Council 1, 2026

Alvin Wong (Lead Author), Jordan Asnicar (Lead Author), Ahir Shankar, Aine Rojo, Emily Chen, Vaneeza Kazmi; with Sricharan Prassannna (National Policy Mentor), Taylor Cabassi (National Policy Mentor), Santi Chua (National Policy Secretary), Aaron Avenido (Global Health Policy Officer), and Swetha Kumar (National Policy Officer)

Reviewed, Council 1, 2023

Meredyth Lee, Patrick Rosengren, Alexandra Wilson, Olusina Omifolaji, Jayatee Banerjee, Isabelle Townend, Kermina Kiriacos; with Ebony Layton (National Policy Mentor) and Connor Ryan (National Policy Officer – Executive).

Reviewed, Council 3, 2019 as a merger of 'Quality Clinical Placements' and 'Shared Clinical Placements'.

Adopted Council 2, 2016 (Quality Clinical Placements).

Reviewed Council 3, 2015 (Shared Clinical Placements).

Adopted Council 1, 2008 (Shared Clinical Placements).

