



CERTIFICATION OF HEALTH PROFESSIONAL OR COUNSELLOR in support of an Application for Special Consideration

The University would be very grateful if you could complete this form on behalf of this student. It will provide the necessary supporting information to assist the University to decide on granting special consideration for this student's exam(s) or assessment(s). Your assistance is appreciated and the University would like to thank you for taking the time to complete this form.

STUDENT DETAILS This Section Must Be Completed

Student Identification Number:

TITLE eg. Mr/Ms/Mrs

SURNAME/FAMILY NAME

GIVEN NAMES

Semester:		Study Year: <input type="text"/>

The following examples indicate how medical conditions might disadvantage students at examination or at other times. You do not need to provide such reasoning unless the student requests this. Your certification will be taken into account, but the final decision will be made by the university.

- Severely disadvantaged at this examination: might be that the student had severe period pain requiring medication that had a sedative effect, in a background of previous problems with and management of period pain.
- or, for example:
- Moderately disadvantaged at other times in their study: might be that the student had medically treated depression with some exacerbations and adjustment of treatment.

CERTIFICATION

1. The above named student consulted with me most recently on these dates			
2. This student has been disadvantaged at their examinations:			ABLE TO SIT THE EXAM(S)
<input type="checkbox"/> Slightly <input type="checkbox"/> Moderately DATE DISADVANTAGED FROM	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Severely <input type="checkbox"/> Very Severely DATE DISADVANTAGED TO	<input type="text"/>		
3. This student has been disadvantaged at times other than or in addition to their examinations:			ABLE TO STUDY
<input type="checkbox"/> Slightly <input type="checkbox"/> Moderately DATE DISADVANTAGED FROM	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Severely <input type="checkbox"/> Very Severely DATE DISADVANTAGED TO	<input type="text"/>		

Is your opinion based on the history supplied by the student alone or supported by additional evidence?

4. Please supply any relevant additional information relating to the ability of the student to prepare for or sit examinations and/or undertake other work for assessment other than examinations.

DECLARATION & DETAILS OF DOCTOR OR COUNSELLOR

I certify that the above student has/has not (please delete inapplicable wording) consulted me on a number of occasions over ____ years. I certify that I have seen the above student regarding this matter recently and the information I have supplied is true and correct.

Signature: _____

Date: _____

Name: _____

Address: _____

DOCTOR'S/
COUNSELLOR'S
STAMP

Postcode: _____

Day time Phone: _____