

Deakin College Health Practitioner Certificate (Special Consideration)

Purpose of this document

This document is to be used when applying for special consideration on medical grounds or psychological for examinations or other assessable work.

Special consideration may be granted to students who are legitimately disadvantaged in their assessment due to circumstances beyond their control.

For special consideration on **medical, health or psychological** grounds to be granted, Deakin College requires information to be provided by the practitioner. This is **to enable an assessment of the validity of the student's entitlement** to be made and, if the student is entitled, to determine what action, if any, should be taken. This form is used to provide this information.

Student Authority for Release of Information (to be completed by the student)

Student Name (BLOCK LETTERS):

Deakin College ID Number:

I hereby authorise the health practitioner to release the information given on this document and I authorise Deakin College to seek further information from the originating source.

Signature: Date:

Health Practitioner Section (all questions to be completed)

1. Practitioner/Provider's Name:

Provider Number:

Address/contact details (phone, email):

Provider's Stamp

2. Consultation Date:

3. Please indicate how your assessment of the student's condition was obtained (please tick):

☐

Information provided by student

☐

Examination of student

4. Period during which the student has been/will be affected (inclusive):

From: To:

5. Determination of ability to sit for an assessment/examination (please tick):

☐

UNABLE to sit/submit an assessment/exam during the dates listed above

☐

ABLE to sit/submit assessment/exam during the dates listed above

6. Condition is (please tick):

☐

Mild

☐

Severe

7. Details of condition (only if necessary/required):

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Practitioner's Signature: Date:

OFFICE USE ONLY Date Received:

<input type="checkbox"/> APPROVED <input type="checkbox"/> NOT APPROVED			
Name of Academic Manager/Coordinator:			
Signature		Date:	
Academic Manager / Course Coordinator			
Comments:			
<input type="checkbox"/> Recorded by Academic Services			
To be completed by Assessor			
Special Consideration provided by:			
<input type="checkbox"/> Increasing the mark for this piece of assessment by%			
<input type="checkbox"/> Other (please comment below)			
Comments:			
Name of Academic Manager/Coordinator:.....			
Signature:		Date:	
Academic Manager / Coordinator			
<input type="checkbox"/> Student Notified		Date:	
<input type="checkbox"/> Lecturer Notified		Date:	