



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  Surname/Family name  First name  Second/Middle name

Semester  Study year

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:

Slightly  Moderately  Severely  Very Severely

Date disadvantaged from  Date disadvantaged to  Able to sit the exam(s)  Yes  No

3. This student has been disadvantaged at times other than or in addition to their examinations:

Slightly  Moderately  Severely  Very Severely

Date disadvantaged from  Date disadvantaged to  Able to study  Yes  No

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

5. 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 HEALTH PROFESSIONAL

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  /  /

Type of Health Professional  Registration Number

Title  Name

Address

Postcode  Day time telephone number

**STAMP OF HEALTH PROFESSIONAL**  
If this form is being submitted digitally then a stamp is not required. However please record your registration number from your professional body.