APPLICATION FOR SUPPLEMENTARY ASSESSMENT ON MEDICAL GROUNDS

IMPORTANT INFORMATION

Regarding the Medical Certificate

1. Forms CS/Med/99A, CS/Med/99B1 and CS/Med/99B2 must be used by all students within the University when an application on medical grounds is lodged for supplementary assessment related to an examination.

2. Forms CS/Med/99A, CS/Med/99B and CS/Med/99B2 must be used by all students within the University when an assignment extension is being sought on medical grounds.

3. Faculties and Schools may require the use of these forms in other circumstances as specified in the individual subject policy.

4. These forms are only relevant for use in University of Adelaide related matters. Please note that in all cases the Medical forms must contain the Medical or Dental Practitioner’s Provider Number where indicated.

These forms must be submitted to the Office of the Faculty/School of ................................................................. and should arrive no later than 7 days after the medical examination.

To be completed by the student

I consent to the University of Adelaide being provided with further information on my medical condition if sought.

...............................................................................              ..............................................                       ...................................
Student Name  Student Signature Date

Completed forms to be returned to the relevant Faculty/School of
The University of Adelaide

(Continued on form CS/Med/99B2)
STUDENT MEDICAL CERTIFICATE

I declare that I am not in a close personal relationship with the student (ie, a relationship which gives rise to a real or potential conflict of interest, such as immediate family, matrimonial (de-facto) and financial relationships).

................................................................................................................................................................
Medical or Dental Practitioner’s Signature Phone No. of Medical Practice Practitioner’s Provider Number

I, ............................................................................. a legally qualified practitioner certify that on ...................................(date of consultation), I examined .................................................................................................... Student Number....................................
(Patient’s name BLOCK LETTERS)

The patient is suffering from...............................................................................................................................................................
(Diagnosis must be in ENGLISH)

The above patient will return on ..........................................................for reassessment of the condition.
(provide date)

EXAMINATIONS

In my opinion the condition will result in:

1. Preparation impaired from ....................................................... to .................................................................

2. Fit to take exam on ................................................................. with no impairment.

3. Fit to take exam on ................................................................. with minor impairment.

4. Fit to take exam on ................................................................. with severe impairment.

5. Unfit to take exam on ............................................................... 

CONTINUOUS ASSESSMENT

In my opinion this condition will affect the following: (Please tick)

Attendance at LECTURES, TUTORIALS

ASSIGNMENTS

PRACTICAL and FIELD WORK

PRIVATE STUDY

This condition or impairment will cover the period .............................................to .........................................................

(date) (date)

ANY OTHER REMARKS:

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