



# PROFESSIONAL AUTHORITY FORM

## Request for Special Consideration Due to Short Term Illness or Misadventure

Information MUST be provided by a professional authority (such as a doctor or allied health professional) who then signs the form and stamps it (if possible). This form must include ALL information requested, or it may not be accepted. Backdated or out of date documentation may also not be accepted.

**TO THE PROFESSIONAL AUTHORITY PROVIDING DOCUMENTATION** - Your help in providing information regarding the student's illness (or other problem) is appreciated. If there is a significant period of impact, or is in your opinion unfit to continue studies for the Term, please note this on the form.

Within the limits of what the student is willing to share, this form and/or any certificate must describe the nature and seriousness of the student's problem so that an assessment of the possible effects of the illness (or other problem) on performance can be made.

**STUDENT'S NAME:** \_\_\_\_\_

**STUDENT ID:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**DATE(S) ON WHICH STUDENT WAS SEEN FOR THIS ILLNESS/MISADVENTURE:** \_\_\_\_\_

**PLEASE OUTLINE NATURE OF THIS ILLNESS / MISADVENTURE AND ANY RECOMMENDATIONS:**

*Please specify if this is self reported, estimated or confirmed.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DATE OR PERIOD OF THIS ILLNESS OR MISADVENTURE:**

**FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

**IMPACT ON STUDENT'S ABILITY TO COMPLETE HOMEWORK/TAKE HOME/ONLINE ASSESSMENTS:**

*Please tick as appropriate*

NO IMPACT  MINOR IMPACT  MAJOR IMPACT  NOT ASSESSABLE

**IMPACT ON STUDENT'S ABILITY TO COMPLETE IN CLASS/ON CAMPUS EXAMS OR ASSESSMENTS:**

*Please tick as appropriate*

NO IMPACT  MINOR IMPACT  MAJOR IMPACT  NOT ASSESSABLE

**PROFESSIONAL AUTHORITY DETAILS**

I declare that I am not a family member, nor do I have a close personal relationship with this student. I authorise the University of New South Wales to contact me or my office/practice to verify the authenticity of this document.

**NAME:** \_\_\_\_\_ **AHPRA or Registration #:** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **PROFESSION** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **PRACTICE NAME:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

*This can be either your professional, or office/practice's email.*

STAMP