Cairnmillar INSTITUTE

Treatment | Education | Research

Health Care Professional Certification

(to be used in support of a student's application for Special Consideration)

THIS CERTIFICATION REPLACES A TRADITIONAL MEDICAL CERTIFICATE
Student to complete and sign to indicate consent for the Health Care Professional to provide this information to Cairnmillar

Please write in BLOCK LETTERS		**Student ID No.**
Family Name:	**First Name:**	
Other Name:	**Trimester**	**Study Year**
Signature		

CERTIFICATION TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

The above named student consulted with me on these dates:

In my professional opinion, this student has been disadvantaged by illness or hardship in respect of the following

	In a Minor Way	Moderately	Severely
Lectures	☐	☐	☐
Assignments	☐	☐	☐
Practical Sessions	☐	☐	☐
Private Study	☐	☐	☐
Examinations	☐	☐	☐

In my professional opinion, this student has been/is: (please tick)

Able to sit an exam(s): ☐Yes ☐No ☐N/A	Able to study adequately for an exam: ☐Yes ☐No ☐N/A
If unable to sit exams please supply dates	If unable to study please supply dates
From ……../……../20…….. to ……../……../20……..	From ……../……../20…….. to ……../……../20……..

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. Please attach this information to this form.

Are you related to the student? ☐Yes ☐No If yes, what is the nature of the relationship?

HEALTH CARE PROFESSIONAL DETAILS & DECLARATION

I certify that I have seen the above student and the information I have supplied is true and correct.		STAMP
Signature:	Date:	
Name: (BLOCK LETTERS)		
Address:	**Daytime Ph:**	
Type of Health Care Professional:	**Provider No:**	