THE UNIVERSITY OF NOTRE DAME AUSTRALIA

SPECIAL CONSIDERATION APPLICATION FORM

Please use BLOCK/CAPITAL letters, indicate with "N/A" where questions are not applicable and tick boxes where appropriate.
Please post or hand deliver completed form to your School **(PO Box 1225, Fremantle, Western Australia 6959)**

For a FINAL INVIGILATED EXAM please submit the completed form to your School NO LATER THAN THREE WORKING DAYS after the invigilated exam.
For a piece of ASSESSMENT DURING SEMESTER please submit the completed form to your Unit Coordinator NO LATER THAN THREE WORKING DAYS after the assessment due date.
You must attach documentary evidence from a third party, eg health professional or doctor, to support your application.

STUDENT DETAILS This Section Must Be Completed

Student Identification Number: | | | | | | | | |

TITLE eg. Mr/Ms/Mrs	**SURNAME/FAMILY NAME**	**GIVEN NAMES**

School		**Course:**	

Contact Details: Home: _____ Work: _____
Mobile: _____ Email: _____

SPECIAL CONSIDERATION REQUESTED FOR: (Ensure **CORRECT** unit code(s) & title(s) are written in **BLOCK LETTERS**).

UNIT CODE	UNIT TITLE	ASSESSMENT DUE DATE	EXAM DATE & TIME	LECTURER'S NAME

DESCRIPTION OF CIRCUMSTANCES: Please state the length of time your studies have been affected (in days , weeks or months)**. Indicate any specific requests. Attach extra pages if needed.**
YOU MUST ATTACH SUPPORTING DOCUMENTATION, eg doctor's certificate or letter from a health professional or counsellor.

Please tick appropriate box:

- ☐ Death or illness of immediate family member**
- ☐ Personal or family trauma or crisis
- ☐ Confidential personal crisis
- ☐ Other……

** Immediate family member: parent, sibling, spouse/partner or child

I declare the details I have supplied to be true and correct.

Student Signature: _____ **Date:** _____

Your School will assess your Special Consideration application and notify you in writing within fourteen days of receipt of your application

DO NOT USE **the *Special Consideration Application* if you require an extension of time for submission of work** – discuss this with your lecturer directly; an **extension of time during examination(s)** – submit an application before the published deadline to the Equity Officer; **an irregularly scheduled/deferred examination** – submit an application for an irregularly scheduled/deferred examination with supporting documentation to your School.

OFFICE USE:

Approved		**Not Approved**		**Informed Student Admin:**	
Signature of Approval:				**Print name:**	

Privacy Statement: The information provided in this form will only be used for the administrative or educational purposes of the University, or in accordance with your specific consent. The University will not disclose your personal information to a third party unless required to or permitted by law or where you have consented to the disclosure. Information relating to how the University collects, uses or discloses your personal information and how you may complain about the University's handling of your personal information is contained in the University's Privacy Policy at: http://www.nd.edu.au/copyright.shtml#Privacy.

You have a right to access your personal information that the University holds about you and to seek its correction. If you wish to access your personal information or inquire about the handling of your personal information, please contact the relevant Campus Registrar via email studentadmin@nd.edu.au

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

CERTIFICATION OF HEALTH PROFESSIONAL OR COUNSELLOR
in support of an Application for Special Consideration

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 eg. Mr/Ms/Mrs	**SURNAME/FAMILY NAME**	**GIVEN NAMES**	
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

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

_____

_____

_____

4. 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 COUNSELLOR

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:** _____

Name: _____

Address: _____

Postcode: _____ **Day time Phone:** _____

DOCTOR'S/ COUNSELLOR'S STAMP

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You have a right to access your personal information that the University holds about you and to seek its correction. If you wish to access your personal information or inquire about the handling of your personal information, please contact the relevant Campus Registrar via email studentadmin@nd.edu.au