Application for Special Consideration:
AAPoly Programs

Program Name: _____ **Student ID No.** | | | | | | | | |

Please write in BLOCK LETTERS

Family Name		First Name		
Other Names		International Student	❍ No	❍ Yes
Email Address				❍ Onshore ❍ Offshore
Mailing Address				
		Contact Ph No:		

REQUEST SPECIAL CONSIDERATION IN THESE COURSE(S)

Unit/Subject Code	Unit/Subject Name	Name of Lecturer / Trainer	Assessment Type	Assessment Due Date / Exam Date

TYPE OF CONSIDERATION SOUGHT

❍ Attendance
❍ Extension of assessment due date
❍ Other (please specify): _____
❍ Deferred test
❍ Final unit ruling

GROUNDS FOR YOUR APPLICATION

- **Attach any relevant supporting documents** (eg. Medical Certificate, Police Report or Statutory Declaration etc).
- Indicate any specific requests in this section

❍ Medical Reasons
❍ Hardship / Trauma
❍ Loss or Bereavement
❍ Other (please specify): _____

Please state length of time (in days, weeks or months) your studies have been affected:

_____

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Additional Information (please provide information about how the event (s) have impacted on your studies and provide details of the specific request (s) you are making. Please note, if you are applying for Special Consideration on medical grounds, you need not provide specific details of a medical condition, but an appropriate/authorised Medical Certificate must be attached.

STUDENT DECLARATION

I acknowledge that disciplinary action may be taken if I knowingly supply false or misleading information. I certify that to the best of my knowledge, the information supplied on this form is true and correct. I am lodging this form no later than 3 days after the due date of assessment or exam listed for special consideration. I understand that if my application is not approved, I can access the Complaints and Appeals procedure (available at http://www.aapoly.edu.au/gcprocedure).

Signature: ..... Date: ....

Attach any documents or evidence to this form

Head of Academic Division / Program Coordinator

❍ Accepted ❍ Rejected ❍ Request further information

Reason(s):

Signature: _____ **Date:** _____

School: _____

Comments:

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Health Care Professional Certification

This certification replaces a traditional medical certificate. Health Care Professionals are asked to read the attached guidelines prior to completing this certification.

Student to complete & sign to indicate consent for the Health Care Professional to provide this information to Academies Australasia Polytechnic

Please write in BLOCK LETTERS

Program Name		Student ID No.	
Family Name		First Name	
Other Names		Contact Ph No.	
Email address			

CERTIFICATION to be completed by Health Care Professional

1. The above named student consulted with me on these dates

2. In my professional opinion, this student has been disadvantaged by illness or hardship in respect to the following:

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

3.

In my professional opinion, this student has been/is: (please circle)							
Able to sit 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 below:				If unable to study please supply dates below:			
From ...../...../20..... to ...../...../20.....				From ...../...../20..... to ...../...../20.....			

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:

5. Are you related to the student? 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:

..... **Postcode:** ..... **Daytime Ph:** .....

Type of Health Care Professional: ..... **Provider No**:.....