



# The University of Sydney

## FACULTY OF ARTS

Application for  
**SPECIAL CONSIDERATION**  
due to serious illness or misadventure

THIS FORM SHOULD BE SUBMITTED TO THE RELEVANT FACULTY OFFICE AS SOON AS PRACTICABLE AND CERTAINLY WITHIN ONE WEEK FROM THE END OF THE PERIOD FOR WHICH CONSIDERATION IS SOUGHT.

SID

Period for which special consideration is sought

□□□□□□□□

from □□-□□-□□□□ to □□-□□-□□□□  
*day month year day month year*

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Other Names: \_\_\_\_\_  
BLOCK LETTERS

Address: \_\_\_\_\_ Post Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Degree: \_\_\_\_\_ Year(1,2,3 etc) \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Semester 1  2

Indicate work for which special consideration is requested, including relevant dates:

Units of Study (Code/Title)	Exam, Essay, Practical, Tutuorial, Other	Due Date

Please state briefly the reason for your application in your own words:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Consideration application received  
Signed: \_\_\_\_\_ Signed: \_\_\_\_\_  
(Faculty Office) (student)  
Date: \_\_\_\_\_ **STAFF: Photocopy of stamped form to student as receipt**

# Professional Practitioners Certificate

To be completed by a registered medical practitioner or counsellor for a student whose work during a teaching period or whose academic performance in an assessment item or items, including examinations, has been affected by serious illness or misadventure.

Special Consideration applications must be supported by documentary evidence from an appropriate professional authority (a registered medical practitioner or counsellor). Certificates signed by family members are not acceptable. Your help providing information about the student's illness or misadventure is appreciated. This information will help the University make a fair and informed assessment about the student's academic performance. The information you provide on this form will be used solely to assess this application.

## PROFESSIONAL PRACTITIONER CERTIFICATE

SID: \_\_\_\_\_ STUDENT NAME: \_\_\_\_\_

Date/s of Consultation \_\_\_\_\_

Please indicate your evaluation of the severity, duration and effect on the student's ability to attend classes, learn, retain and/or complete assessment requirements:

Specify period/duration

Severity (please tick appropriate boxes)	√	from	to
Totally unable to study			
Very severely affected			
Severely affected			
Moderately affected			
Slightly affected			
Unable to assess			

**Plain English description of: nature of illness, symptoms, restrictions on capacity or functionality in their studies and other relevant information (attach additional report or documentation if necessary, bearing in mind privacy requirements)**

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OTHER (please specify and attach documentation/evidence)

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Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number \_\_\_\_\_ Provider Number \_\_\_\_\_ Stamp \_\_\_\_\_

**I authorise the University to contact me or my office to confirm authenticity of this document.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_