Australian National University

SPECIAL CONSIDERATION APPLICATION - SUPPORTING DOCUMENTATION

TO BE COMPLETED BY MEDICAL PRACTITIONER / COUNSELLOR or ANU DISABILITY ADVISOR (upon receipt of current appropriate supporting medical documentation)

Student No.	Family Name	Other Names

Date on which student was seen: _____

Date of first onset: _____

Expected duration of illness or other causes (days/weeks/indefinite): _____

Your assessment of the severity of the illness or other causes (please tick as appropriate).

❑ Mild ❑ Moderate ❑ Severe ❑ Other (Please Specify)

Nature of illness/problem/disability and likely affect on academic performance: **PLEASE USE BLOCK LETTERS**

_____

_____

_____

_____

_____

_____

IMPORTANT

In your opinion, does this medical condition affect this student's performance when completing the assessment(s)/ examination(s) listed above.

YES ❑ **NO** ❑

TO BE SIGNED BY MEDICAL PRACTITIONER, COUNSELLOR ETC.

Name: _____

Signature: _____ Date: _____

Address: _____

_____ Post Code: _____

Please affix your Practice Stamp or seal to certify authenticity

The University will retain original medical documentation