Medical/Health Professional Assessment Form

Thank you for taking the time to complete this form on behalf of this student. It will provide important information that will allow the University to make a decision regarding the student's capacity to study through the affected study period.

Student Details - to be completed by student

Surname		Given names	
Student ID		Studies affected in year (eg. 2021)	
Teaching period		Census date	

Medical/Health Professional Assessment

The above-named student consulted with me most recently on these dates:

Does this student have a condition which has affected their capacity to complete their units in the above-mentioned teaching period?	☐ Yes	☐ No
Does this student have an ongoing condition (i.e does it predate the above-mentioned Census date)?	☐ Yes	☐ No

Has this condition worsened/deteriorated since the above-mentioned Census date?

☐ Yes Occurred on: Worsened/deteriorated on:	☐ No Occurred on:

In my professional opinion, the student will be/was fit to resume studies from:

As this student's medical/health professional, I would support and recommend:

☐ Full study period withdrawal (no units/studies to be undertaken in the above-mentioned teaching period).

☐ Partial withdrawal (reducing study load) with the student fit to complete ____ units in the above-mentioned teaching period.

☐ No withdrawal from unit/s, student was/is fit to continue with their studies in the above-mentioned teaching period.

Is your opinion based on the history supplied by the student alone, supported by additional evidence, or based on your history working with/supporting the student?	☐ History supplied by the student alone ☐ Supported by additional evidence ☐ History working with/supporting the student

Please supply any relevant additional information:

Medical/Health Professional Declaration and Details

I declare that:

a) the student presented to me in person.
b) I am not a family member and do not have a close or personal relationship with this student.
c) the information I have supplied is true and correct.

Name	
AHPRA registration number	
Address of practice	
Email	
Signature	
Date	

Medical/Health Practitioner's Stamp