Top Education Institute
Sydney City School of Business | Sydney City School of Law

SPECIAL CONSIDERATION FORM

Step 1: Personal Details

Student number: _____ **Course:** _____

Surname: _____ **Given name(s):** _____

Step 2: Units Applied for Special Consideration (including internal assessment and final examination)

UNIT CODE: _____

Assessment Affected: _____

e.g. Assignment, mid-term exam, final exam, etc.

Step 3: Reasons and Evidence for Applying Special Consideration

☐ **Written statement from the student explaining why special consideration is sought:**

_____

_____

_____

_____

_____

☐ **Attached documentary evidence**

☐ If your application for special consideration is based on medical reasons, please refer to page 3 and complete Parts A and B.

☐ If your application is based on other reasons, please attach relevant documents to support your application.

Step 4: Student Declaration

I have read and understood the assessment submission requirements in relevant unit outline and have read and understood Top Education Institute's Examination Policy.

I understand that by signing this form I confirm that all the information provided and all the documents attached are true and accurate.

Student signature: _____ **Date:** ____ / ____ / _____

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Step 5: Final Decision by Academic Department

TOP OFFICE USE ONLY

Comments: _____

_____

_____

_____

☐ **Approved** ☐ **Rejected**

Signature: _____

Position: _____

Date ____ / ____ / ____

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STUDENT MEDICAL CERTIFICATE

This document is used to apply for special consideration on medical grounds for assessments (including examinations) at Top Education Institute.
Top Education Institute requires information provided by a medical practitioner or health care provider, which will assist the Institute to decide on granting special consideration for this student's assessment(s).

Part A: STUDENT DETAILS AND AUTHORITY

Student Name (BLOCK LETTERS): …… Student ID: ……

I hereby authorise the medical practitioner or health care provider to release the information given on this document and I authorise Top Education Institute to seek further information from the originating source if needed.

Signature: …… Date: ……

Part B: MEDICAL PRACTITIONER DETAILS AND ASSESSMENT

I …….. (NAME), a registered medical/ health practitioner, declare that I had a consultation with the above student on ……./……./…….and determined the student is suffering from ……

The authorised period during which the student has been/will be affected:

From…… To…….

How many times has the above patient consulted you for professional advice over the past 12 months……

Degree to which this student's performance was/will be affected. (Please tick)

None	Mild	Moderate	Severe
The condition has no impact upon their ability to undertake their assessment task	The condition has caused considerable discomfort to the student, but has not had a severe impact upon their ability to complete the assessment task/attend classes	The condition has seriously impacted on the students ability to complete an assessment task at their normal level of competence/attend classes	The condition has affected the student to such an extent that they are totally unable to undertake the assessment task/attend classes

I declare that I am not a family member and do not have a close or personal relationship with this student. I declare that I have seen the above student regarding this matter recently and the information I have supplied is true and correct. I authorise Top Education Institute to contact the clinic for verification.

Signature: …… Date: …….

Medical Centre ……..

Address ……

Contact Number……. Provider No ……

Providers Stamp