PROFESSIONAL AUTHORITY FORM

ALL FIELDS MUST BE COMPLETED BY A REGISTERED HEALTH PROFESSIONAL OR FOR NON-MEDICAL REASONS A RELEVANT PROFESSIONAL (I.E. LEGAL PRACTITIONERS/ POLICE) ON OR BEFORE THE DATE OF THE ASSESSMENT TASK/OR EXAMINATION. CERTIFICATES FROM TRADITIONAL MEDICAL PRACTITIONERS WILL NOT BE ACCEPTED.

1. INSTRUCTIONS TO THE PROFESSIONAL AUTHORITY PROVIDING DOCUMENTATION

We appreciate your help in providing information regarding the student’s health condition(s). The information that you provide will enable SIBT (as the educational institution) to determine the impact of the impairment on the student’s ability to meet academic assessment requirements.

Within the limits of confidentiality, this form and/or certificate, must describe the nature and impact of the student’s problem so that an assessment of the possible effects on academic performance can be made.

2. PERSONAL DETAILS OF STUDENT

Student Name ___________________________ Student ID ___________________________

3. CONSULTATION

Date of Consultation: ___________________________ Duration of condition or disruption ___________________________

From: / / To: / /

NOTE: For chronic health conditions, only complete this form if there has been a considerable and unpredictable exacerbation of symptoms that have impacted the student’s academic functioning.

Nature of condition: Please provide a plain English description of any restrictions on the student’s academic functioning (eg reading, writing, learning, memory, concentration etc.) as a result of the health condition(s); details of the medical diagnosis are NOT required:

________________________

Impact of condition: Please indicate your evaluation of the likely impact of the health condition(s) on the student’s ability to attend class, learn, retain or complete assessment requirements by marking the scale below.

1 Able to study 2 Limited capacity to study 3 Unable to study

Name of Professional: ___________________________

Signature of Professional: ___________________________

Business/ Institution name: ___________________________

Provider or Registration Number: ___________________________

Contact phone number: ___________________________

Stamp of Professional Authority

Please note that SIBT collects information from students to enable their request to be considered. Provision of this information is voluntary, but if the student does not provide the information as requested, SIBT may be unable to process their request. Personal information held by SIBT is subject to the Privacy and Personal Information Protection Act, 1998 (NSW)

4. INSTRUCTIONS FOR STUDENTS:

THIS PAF NEEDS TO BE UPLOADED ONLINE AS PART OF YOUR SPECIAL CONSIDERATION APPLICATION

Reference Number: F1.88 Version: 6 Page 1 of 1

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