



STUDENT ADMINISTRATION

MEDICAL CERTIFICATE

STUDENT CENTRAL LOCKED BAG 1797, PENRITH NSW 2751

This form is to be used when a Medical Certificate is required as documentary evidence.

Please complete this form in **BLACK INK** using **CAPITAL LETTERS**. Mark appropriate answer boxes with a cross (X).

You may apply for a Disruption to Studies provision if you experience serious misadventure, accident or extenuating circumstances beyond your control that impacts your studies for <u>at least three consecutive days</u>.

Visit westernsydney.edu.au/specialconsideration for more information on Disruption to Studies. You can view full details of the Disruption to Studies policy under 'D' in the A-Z policy list at westernsydney.edu.au/policy.

1 - PERSONAL DETAILS		
Student ID number	Daytime contact phone number	
Title Family name		
Given name(s)		
2 - MEDICAL CERTIFICATE		
The certificate must be completed by a registered medical practitioner and have the practitioner's provider stamp affixed. Stress and/or anxiety associated with exams will not normally be considered.		
Name of practitioner	ou man oxumo min nocino muniy ac constaticui	Provider's stamp
Provider number		MUST BE
Address		AFFIXED HERE
Contact telephone(s)		If stamp is not available, a signed declaration of provider number on practitioner's letterhead
Date of attendance at surgery	Date D D / M M / Y Y Y Time	is to be attached to this application.
I certify that	PATIENT'S NAME	
is unfit for studies from	Date D / M M / Y Y Y Date D / M	M / Y Y Y Y
Is the patient's condition severe assignment, class work, fieldwo	e enough that it prevents them from completing an ork or exam?	No
My assessment of the patient's	condition was based on:	
an examination of the patie	nt information provided by the patient	
I am unable to assess how t	his illness would affect the patient's capacity to sit a formal exam	
Within the limits of patient con over this period.	fidentiality, please state the nature of the problem/illness/difficulty experi	enced by the patient
Practitioner's signature	PRACTITIONER'S SIGNATURE Date D D /	M M / Y Y Y
All sections of this form must be completed.		

In providing my personal information to the University, I understand that, other than as authorised by law, the University will only use this information for the purposes for which it is being collected in accordance with the University's functions and activities associated with my enrolment. In some instances, the University may need to disclose information to any Government department which administers or has authority regarding education or immigration policy and law and any other Government agencies (State, Territory or Federal, an affiliated entity of the University, or to third parties for the purposes of recovering unpaid University fees or other debts owed to the University, and I consent to such disclosure. I also understand that all information will be collected, stored, accessed and disseminated or destroyed in accordance with privacy, records management and other relevant laws, and the University's policies.

Page 1 of 1 00372 08/16