UTS

PROFESSIONAL AUTHORITY FORM

Student Number: ____________________________ **Student Name:** ______________________________

For health-related matters:
This form must be completed by a registered medical practitioner, psychologist, counsellor or other registered health practitioner for a student whose work during a teaching period or whose performance in an assessment item or items, including examinations, has been affected by illness or other medical cause.

Practitioner Registration Number (AHPRA) and Medicare Provider Number must be provided by the registered practitioner.

Health-related matters include:
A serious illness or psychological condition, loss/bereavement or hardship/trauma.
Your help in providing information about the student's illness is appreciated. This information will help the University make a fair and informed assessment about the student's academic performance. The information you provide on this form will be used solely to assess this application.

Note: Students who have experienced a misadventure or non-health related matter must provide a letter on official letterhead from a funeral director, minister of religion, counsellor or professional/official body.

REMARKS: please indicate the nature of illness/symptoms; or other cause, including restrictions on capacity or functionality and other relevant information (attach additional report or documentation if necessary)

Please indicate below your evaluation of the severity, duration and effect on the student's ability to attend classes, learn, retain and/or complete assessment requirements:

Severity (please tick appropriate boxes)	√	**Specify period/duration** **From** (dd/mm/yy)	**To** (dd/mm/yy)
totally unable to study			
very severely affected			
severely affected			
moderately affected			
slightly affected			
unable to assess			

Date/s of consultation:

Profession/Position:

Name:

Address:

Phone:

Medicare Provider Number:

(xxxxxxA)

Practitioner Registration Number*:

(MED000xxxxxxx)

Stamp:

I authorise the University to contact me or my office to confirm authenticity of this document.

Signature:

***Required for AHPRA - Australian Health Practitioner Regulation Agency registered professionals**