MEDICAL EVIDENCE FORM

Please hand this form to your Medical Practitioner or Health Professional along with a copy of your Special Consideration Application Form

To be completed by your Medical Practitioner or Health Professional

If circumstances prevent the applicant for Special Consideration for admission to Curtin University from having this form completed please complete the statement to this effect at the end of the form and submit the form along with your Special Consideration Application

The University will accept documentation from appropriately qualified health practitioners including - general medical practitioners, medical specialists, psychologists, occupational therapists, physiotherapists, speech pathologists, social workers, optometrists, and audiologists.

Name of Medical Practitioner / Health Professional:		Official stamp of clinic
Name & Address of Hospital / Clinic / Surgery:		
Contact details: Telephone: Fax: Email if appropriate:		

I certify that I examined .....
FAMILY NAME (capitals) First Name (not capitals)

☐ Male ☐ Female Date of Birth of patient/client : ..... (dd / mm / yyyy)

From _____ to _____ (Date/s of consultation)
(dd / mm / yyyy) (dd / mm / yyyy)

Medical Diagnosis

(This will be dealt with in the strictest confidence. Please provide all relevant information related to the applicant's basis of their request for special consideration. Please provide an indication of the severity of the condition and its impact on the applicant's ability to study in the last year prior to University entrance examinations.)

Please supply further details in a separate statement if required.

Date of onset of condition / problem : ..... (dd / mm / yyyy)

Severity of condition/impact:

Place X in appropriate box	MILD	MODERATE	SEVERE	CHRONIC/ONGOING
Severity of condition/problem:	☐	☐	☐	☐
Severity of impact on applicant's study during the year the applicant sat University entrance examinations:	☐	☐	☐	☐

Declaration of Medical Practitioner / Health Professional

I declare the above information to be accurate and complete and that the above condition/problem affected the applicant in their studies / preparation for the WACE Examinations (or equivalent).

Signature: .....Date: .....

This form should be completed and returned to the applicant for inclusion in their application.

Declaration of Applicant for Special Consideration

I declare that I have attempted to have this Medical Evidence Form completed by my Medical Practitioner or Health Professional. The following circumstances, beyond my control, have prevented me being able to have this form completed.

Circumstances: .....

Signature: .....Date: .....