ACA44a – Confidential Medical/Psychological Report

(in support of Deferred Exam Application)

IMPORTANT

1. Please note that this form is only to be completed if you are requesting deferment on **medical/psychological grounds**. It is confidential and will be seen only by the Deferred Examination Committee.
2. Please note that if it is a recurring medical/psychological condition, **all the relevant reports** must be submitted to provide **evidence that you have been under professional care since the condition was first diagnosed**.
3. The consultation must take place **before** or **on** the day of the exam.
4. This form should be submitted together with the **ACA44: Deferred Exam Application Form** as a single, combined PDF.
5. **Read** the **Student Wellness Services supplementary information (ACA44aHLP)**.

NOTE: A DOCTOR'S CERTIFICATE IS NOT SUFFICIENT – THIS FORM MUST BE COMPLETED IN FULL, i.e.:

- **Section A and Section B must be completed by the student applicant;**
- **Section C by the health professional.**

SECTION A: STUDENT APPLICANT DETAILS **Note:** To be completed by the student									
A.1 Student Name									
A.2. Student Number									

SECTION B: DECLARATION AND INFORMED CONSENT GIVEN BY THE STUDENT APPLICANT **Note:** To be completed by the student			
B.1 I acknowledge that:	The health professional does not have any influence on the decisions of the Deferred Examination Committee.		
B.2 Student's informed Consent (name and surname)	**I**, hereby voluntarily request and grant permission to my healthcare practitioner to provide my diagnosis on this form, for the purpose of this application.		
B.3 Student Applicant's Signature		**Date** (*dd/mm/yyyy*)	

Student Name		**Student Number**									

SECTION C: MEDICAL/PSYCHOLOGICAL REPORT

Note: To be completed by the health professional (in public or private practice, or at SWS)

Date of consultation (Date health professional consulted with patient, not the date of when the illness started)	

Type of consultation (tick one)	**In-person**	☐
	Remote	☐

Indicate any family relationship to student	

Clinical information (required)

Diagnosis (required)

Declaration (required)	This is to certify that I have examined the above patient, and the patient has been booked off (**tick the appropriate option/s**):	according to my findings	☐
		as I was informed	☐

From (*dd/mm/yyyy*)		**To** (*dd/mm/yyyy*)	
Health Professional's Name (*Please print)*		**Phone Number**	
		Reg. Number and professional body	
Professional Qualification			

It is within my scope of practice to book students off	**YES**	☐	**NO**	☐

Practice Address	

Health Professional's Signature		**Health Professional's Stamp**	