UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

Office of the Deputy Registrar
Student Records Section

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 (which may be remote) 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.

SECTION A: STUDENT APPLICANT DETAILS **Note:** To be completed by the student									
A.1 Student Name									
A.2. Student Number									
A.3 Faculty									
A.4 Degree									
A.5 Reason for request: Briefly explain why you are applying for a deferral of your examination/s									
A.6 Student's contact numbers									
A.7 Living on campus	**Yes** ☐			**No** ☐					

SECTION B: DECLARATION AND INFORMED CONSENT GIVEN BY THE STUDENT APPLICANT **Note:** To be completed by the student		
B.1 Student Declaration	I declare that the information provided in **Section A** above is true and correct**.**	
B.1.1 I acknowledge that:	The role the health professional is to provide clinic-based therapeutic services and the health professional does not have any influence in the decisions of the Deferred Examination Committee.	
B.1.2 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.1.3. Student Applicant	**Signature**	**Date**

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	In **person** ☐	**Remote**	☐
Indicate any family relationship to student			

Clinical information and diagnosis

This is to certify that I have examined the above patient and ☐ according to my findings / ☐ as I was informed the patient has been booked off (tick appropriate options)

From		**To**	
Health Professional's Name (*Please print)*		**Phone Number**	
		Reg. Number (HPCSA/SANC/SACSSP)	
Professional Qualification			
Address			
Health Professional's Signature		**Health Professional's Stamp**	