International Institute of Business & Technology Australia

Special Consideration Request Form

Please read the Special Consideration policy carefully before completing this form.

Personal Details

Student ID: _____ **Course:** _____

Family Name: _____ **Given Names:** _____

Contact Phone Numbers (day): _____ **(other):**_____

Email: _____

Period for which Special Consideration is sought

FROM: _____TO: _____

Unit(s) for which Special Consideration is sought:

Unit Code	Unit Title	Assessment due date/ Examination date	Academic Teacher /Trainer Name

Reasons for the application: (please attach additional pages if required)

_____

_____

_____

_____

Student Declaration

I confirm that all information, including supporting documentation and certificates, is correct. I hereby authorise IIBT to contact the professional authority concerned for the purpose of verifying any information I have supplied.

SIGNATURE:_____DATE: _____

Please return this form to IIBT Reception.

Office use only			
Received by:		**Date received:**	

International Institute of Business & Technology Australia

CERTIFICATION OF HEALTH PROFESSIONAL OR COUNSELLOR

IIBT would be very grateful if you could complete this form on behalf of the student. It will provide the necessary supporting information to assist the college in assessing the student's request for Special Consideration in respect to the student's examination (s) or assessment (s).

Information in this section MUST be provided by a professional authority (such as a doctor or counsellor) who stamps and signs the form. **If the practitioner does not have the facility to stamp this form, a separate official certificate should be attached providing all information requested.**

Within the limits of confidentiality, this form and/or any certificate must describe the nature and seriousness of the student's circumstances so that an assessment of the possible effects of the situation on academic performance can be made.

CERTIFICATION

Student Name: _____

Dates on which student was seen: _____

Nature of illness/injury/issue: (Attach additional statement if necessary)

_____

_____

_____

_____

_____

_____

Date (s) of illness/injury/issue: _____

Assessment of severity of illness/injury/issue:

Mild ☐ Moderate ☐ Severe ☐

Assessment of likely effect on student capacity to undertake assessment:

Mild ☐ Moderate ☐ Severe ☐

DECLARATION OF HEALTH PROFESSIONAL

I certify that the above information is true and correct

Practitioner Stamp

NAME: _____

SIGNATURE:_____

CONTACT NUMBER:_____DATE: _____