

Application for special consideration (Vietnam campus)

RMIT student number _____

Section E – Impact assessment statement – for a special consideration application on health/medical grounds

Please note: This impact assessment statement (IAS) is the best way to establish medical/health grounds for a special consideration application. A standard medical certificate can also be accepted if it states the dates and nature of the impact. If difficult personal circumstances are impacting your health, wellbeing and studies and you're unable to provide other supporting evidence, you may provide a completed IAS. This IAS must be completed by the registered medical/health practitioner who treated you for the condition (or supported you with your difficult circumstances). You may also include other documentation such as a letter from the practitioner.

I agree to RMIT University contacting my medical/health practitioner as necessary to clarify the information provided below.

Student signature _____ Date (DD/MM/YYYY) _____

Section F – Medical/health practitioner assessment

On (date/s of consultation) _____

I (name), _____ a registered medical/health practitioner, examined

Student name _____ Student number _____

and have determined that they are suffering from _____
(condition to be stated with student's consent)

or the student reports that they are suffering from _____

From date (DD/MM/YYYY) _____ to date (DD/MM/YYYY) _____

The condition is permanent infectious episodic/fluctuating deteriorating improving

Please indicate your professional assessment of the type and level of impact of the condition on the student's activities.

Description of impact of the medical/health condition	Additional information	Dates affected	From (DD/MM/YYYY)	To (DD/MM/YYYY)
1. Able to travel/attend <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> as determined above <input type="checkbox"/> dates within the following		
2. Able to do sustained reading, note-taking and writing <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, able to work <input type="checkbox"/> as usual <input type="checkbox"/> moderately less than usual <input type="checkbox"/> significantly less than usual	<input type="checkbox"/> as determined above <input type="checkbox"/> dates within the following		
3. Able to perform a task requiring intense concentration for 1–2 hours <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, able to complete <input type="checkbox"/> as usual <input type="checkbox"/> significantly less than usual	<input type="checkbox"/> as determined above <input type="checkbox"/> dates within the following		

Additional information (complete as needed)

Practitioner's signature _____ Date (DD/MM/YYYY) _____
and stamp

Hospital/Clinic's stamp

Complete only for details not provided in the stamp

Practitioner registration number _____

Address of practice _____

Tel. _____ Fax _____

Email _____