

This form must be completed by a registered health care professional within their scope of practice.

It must not be completed by a family member or someone with a personal relationship to the student.

International students should note that the University may verify the information collected on this form. Submitting fraudulent medical documentation could result in suspension or exclusion from the University.

Important information

This form supports a student's application to change their study arrangements at Adelaide University due to health-related circumstances. These changes may include:

- Leave of Absence (pausing studies for up to 6 months)
- Reduced Study Load (taking fewer courses in a semester or trimester)
- Release (transferring to another education provider within the first 6 months of study)

Your assessment will help the University determine whether the student's situation meets the Australian Government's requirements for **compassionate or compelling circumstances beyond the student's control**, as outlined in the ESOS Act 2000 and National Code of Practice (Standard 9).

These **circumstances must significantly impact** the student's ability to progress in their program or affect their personal wellbeing (e.g. serious physical and/or mental health conditions).

⚠ Note: Mild, short-term conditions like flu type illnesses, homesickness, or temporary adjustment difficulties are usually not considered compassionate/compelling grounds.

How to complete this form

Please complete this form based on your professional assessment of the student's health condition.

Include the following details:

- Your full name, provider/registration number, and **contact information**
- The **date of the consultation**
- The nature of the **medical condition**
- Your evaluation of the **duration** and **impact** of the medical condition on the student's ability to study, attend class, or complete assessments
- **Treatment plan**
- The **date of form completion** and your **signature**

Privacy and Verification

The information you provide will be used only by authorised University staff for the purposes of assessing this request and will be managed in accordance with **Adelaide University's Privacy Policy**.

You may be contacted to verify the details you have provided.

Registered Health Care Professional Details

Full Name:

Contact number:

Address:

Provider/Registration number:*I declare that I am not a family member and do not have a close or personal relationship with this student. I authorise Adelaide University to contact me or my office to confirm the authenticity of this document.***Health care professional signature:****Date form issued:**

Health Care Professional Stamp

Student Information and Authority

Student ID number:

Family name:

Given name(s):

*I hereby consent to relevant information being provided by my health care professional and agree that they may provide verification of this statement if requested by Adelaide University. I understand that I must retain the originals of any documents submitted in support of a change of study arrangements request and that Adelaide University may require the originals to be supplied at any time during my enrolment until my degree has been conferred, or my enrolment otherwise terminated.***Student's signature:****Date:****Assessment of student****Date of assessment:****Will the student's symptoms/condition last for more than 14 days? (please tick)**Y N **Date symptoms/condition commenced:****Period covered by this assessment:****Nature of medical condition:****Impact on the student's capacity to undertake study:**

Treatment plan:

Office Use Only

Comments:

Outcome:

Date received:

Date processed:

Received by:

Processed by: