

# MEDICAL CERTIFICATE



## IMPORTANT INFORMATION

- This form is to be used by students for the purpose of providing medical evidence to support their application.
- Students applying for special consideration based on medical grounds MUST have a registered medical practitioner complete this form. Independent medical certificates will not be considered, unless the certificate contains information as requested under MEDICAL EVIDENCE.

### Please forward the completed form with the Reduced Study Load application to:

USC Student Services & Engagement – ML23  
MAROOCHYDORE DC QLD 4558,  
Email: studentcentral@usc.edu.au

## 1.0 MEDICAL EVIDENCE

Medical Practitioner confirmation **MUST** include:

- when the patient was examined; and
- when the illness commenced; and
- when the illness ended (if applicable); and
- the severity of the illness, expressed as a medical opinion. (Certificates merely reporting the student's account of the illness will not be accepted.)

## 2.0 MEDICAL CERTIFICATE - ALL fields must be completed

I, <input type="text" value="(Name)"/>	a legally qualified medical practitioner,
certify that on <input type="text" value="Day / Month / Year"/>	I examined
<input type="text" value="(Patient's name)"/>	<input type="text" value="(Patient's date of birth – Day / Month / Year)"/>

Date circumstances / illness commenced:

Date circumstances / illness no longer evident (if applicable):

On what date did the patient's circumstances prevent them from studying:

The patient is suffering from:

NOTE: Diagnosis to be provided with patient consent where possible. Where the nature of the complaint cannot be divulged for privacy reasons, the University will accept a statement from the medical practitioner indicating that the condition cannot be revealed.

Tick applicable box(es) below:

- I certify that due to their circumstances / illness the patient is medically unfit to continue his / her studies for the dates stated above.
- The following information is also pertinent for assessment of the patient's application (please attach additional documents if preferred):

Are you this student's regular Doctor?  Yes  No

Doctor's name, address, contact details and provider number: (OFFICIAL STAMP)

Doctor's signature: <input type="text"/>	Date: <input type="text" value="DD / MM / YY"/>
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