

Course transfers – exceptional circumstances is intended for serious illness/injury/condition or extraordinary circumstances that has a negative impact on student’s ability to continue studies at their current campus.

For Course transfers – exceptional circumstances to be considered, the university requires information provided by a professional practitioner or evidence of exceptional circumstances. This is to determine what action, if any, should be taken if a student is eligible for a course transfer due to exceptional circumstances. A standard medical certificate is insufficient and will **not** be accepted.

Student name _____ **Student ID** _____
Course code and name _____
Current campus _____ **Requested campus** _____

Section 1A Medical reasons: Professional practitioner to complete

Date of consultation:

/ /

I have consulted and examined

I have determined that he/she is suffering from:

OR

e.g. a medical condition (nature of condition not required)

the student reports that he/she is suffering from:

e.g. a medical condition (nature of condition not required)

I consider this condition to be (please tick one):

- short-term (days/weeks) temporary (3-6 months) chronic

Over what period of time have you been treating the student? _____

What impact do you consider the condition will have on the student’s ability to participate/complete/attend assessment task/s:

Impact	From (date)	To (date)
<input type="radio"/> Total incapacitation The impact of the condition is extremely serious in nature and would be expected to prevent the student from being able to participate/complete/attend assessment task/s at their current campus.		
<input type="radio"/> Severe impact on the ability to complete studies at current campus The impact of the condition is serious in nature and would be expected to severely affect the student’s ability to participate/complete/attend assessment task/s at their current campus.		
<input type="radio"/> Moderate impact on the ability to complete studies at current campus The impact of the condition is not severe and would be expected to have a moderate impact on the student’s ability to participate/complete/attend assessment task/s at their current campus.		
<input type="radio"/> Minor impact on the ability to complete studies at current campus The impact of the condition is not serious and would not be expected to have a significant impact on the student’s ability to participate/complete/attend assessment task/s at their current campus.		
<input type="radio"/> No impact on the ability to complete studies at current campus The condition would not be expected to have any impact on the student’s ability to participate/complete/attend assessment task/s their current campus.		
<input type="radio"/> Unable to assess the ability to complete studies at current campus The impact of the condition is not able to be determined (i.e. the condition cannot be diagnosed; there is no visible/discernible condition). <i>Comments:</i>		

Practitioner name and speciality type (e.g. General Practitioner, Psychologist, etc.):

Practitioner signature:

Address:

Phone number:

Date:
 / /

Professional practitioner’s stamp

Section 1B: Student to complete

I hereby authorise the professional practitioner to release the information given on this document and I authorise La Trobe University to seek further information from the originating source.

Student name:

Student signature:

Date:

D	D	/	M	M	/	Y	Y	Y	Y
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Section 2A: Non-medical reasons: Student to complete

Please provide a description of your non-medical reasons as to why you are seeking to transfer from the campus where you are currently studying. If your situation requires special support services please explain what specific support services are available at the campus that you are applying to that are not available at your current campus.

Section 2B: If your application can be supported by a Professional please ensure Section 2B is completed: Professional to complete.

Provide comments related to the students application to transfer from their current campus.

Professional's name:

Professional's signature:

Address:

Phone number:

Date:

D	D	/	M	M	/	Y	Y	Y	Y
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Professional's stamp

Section 2C: Student to complete

I hereby authorise the Professional to release the information given on this document and I authorise La Trobe University to seek further information from the originating source.

Student name:

Student signature:

Date:

D	D	/	M	M	/	Y	Y	Y	Y
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Office use only

HOS 1 Further information required Y/N Approved Y/N
Comments

Name _____ Signature _____

HOS 2 Further information required Y/N Approved Y/N
Comments

Name _____ Signature _____