

ELIGIBILITY

In the event of a missed final examination, a student will not normally be permitted to undertake a deferred examination unless there were unavoidable, compassionate, or compelling circumstances. Please refer to the [ACPE Examinations Policy](#) for circumstances which may be considered for approval.

SUPPORTING DOCUMENTATION

All applications for a Deferred Final exam must include supporting documents as evidence to support your claim. Students applying due to medical grounds must have a registered Medical Practitioner complete the attached ACPE medical certificate.

SUBMISSION DETAILS

Applications with supporting documentation must be lodged **no later than 5.00pm 2 working days after the submission date** of the assessment task. Complete this form, sign, and date the declaration below, and upload this form to [MyACPEportal](#) (Choose **Academic Support**)

OUTCOME

Once the application has been assessed, the student will receive notification of the outcome via their ACPE email account. Approved Deferred final exams will normally be conducted within a 2-week period, following the final exam week. An examination may be deferred no more than once, after the original scheduled examination.

Personal Details

Student ID No.						Phone Number									
Given Name						Family Name									
Course Name						Mode of Study (Online or On Campus)									
Head of Dept. (Tick one)	<input type="checkbox"/> Diane Grant (Education & Dance)		<input type="checkbox"/> Duncan Greig (Sports Performance)			<input type="checkbox"/> Mikah van Gogh (Health Science)			<input type="checkbox"/> Duncan Tweed (Sports Business)						

Unit Examination Details

Exam Date	Unit Code	Unit Name	Lecturer Name	Office Use Only. Approved? (Tick one)
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No

Reason for Deferred Exam Application

Please provide an explanation of the reason for your request below and tick the applicable box. (Also note the documentation required)

Tick the most applicable box below to indicate the reason for your request. **NOTE:** Evidence must be provided (with this application) to demonstrate why you were unable to sit your final examination at the scheduled day and time.

<input checked="" type="checkbox"/>	Serious illness An ACPE Medical Certificate must be completed by a registered Medical Practitioner, with a provider stamp on the certificate that contains their provider number.	<input checked="" type="checkbox"/>	Death or serious illness of immediate family member Please attach a letter from a doctor, funeral director or counsellor, indicating the relationship of the family member to the student.
<input checked="" type="checkbox"/>	Unavoidable commitments Examples include: jury duty, court appearance, military reserve, emergency service. Please attach documentation showing compulsory attendance dates.	<input checked="" type="checkbox"/>	Substantial change to routine employment Please attach a letter from your employer explaining the change to your work arrangements.
<input checked="" type="checkbox"/>	Selection to represent at International, National or State Level in a sporting or cultural event Please attach supporting documentation from State, National or Cultural organization advising of selection and dates.	<input checked="" type="checkbox"/>	Crisis/Trauma For example, family breakdown, victim of crime/accident, extreme financial hardship. Supporting evidence may include a medical certificate or letter from a counsellor, psychologist, doctor, police or fire officer, depending on the nature of the issue. There must be evidence to demonstrate the severity of the circumstance.

Applicant Declaration

I declare that the information provided by me on this form including my supporting documentation, is true and accurate to the best of my knowledge. I acknowledge that disciplinary action may be taken if I knowingly supply false or misleading information. I am lodging this form no later than 2 working days after the published Final Exam day and time.

Student Signature		Date	DD / MM / YYYY
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Office Use Only

Application Assessment	<input checked="" type="checkbox"/> Approved	<input checked="" type="checkbox"/> Denied	Comment			
	Staff Name		Signature	Date	DD / MM / YYYY	

ACPE MEDICAL CERTIFICATE

THIS FORM IS USED IN CONJUNCTION WITH THE ACPE SPECIAL CONSIDERATION FORM.

Please complete this form in **BLACK INK** using **CAPITAL LETTERS**.
 Students applying for a Deferred Exam based on medical grounds **MUST** have a registered Medical Practitioner complete this form.
 Further information regarding Examinations is available at acpe.edu.au/exams

1. Personal Details

Student ID No.						Daytime contact phone number										
Given Name						Family Name										
Course Name																

2. Medical Certificate

This certificate must be completed by a registered medical/health practitioner and have the practitioner's provider stamp affixed.

Name of Practitioner											Provider's stamp MUST BE AFFIXED HERE <small>If stamp is not available, a signed declaration of provider number on practitioner's letterhead is to be attached to this application.</small>				
Provider number															
Practice Address	Street No.& Name														
	Suburb						State								
Contact telephone no.															
Date of attendance at surgery	Date	D D / M M / Y Y Y Y					Time								

I certify that	PATIENT'S NAME														
is unfit for studies from	Date	D D / M M / Y Y Y Y					Date	D D / M M / Y Y Y Y							

Is the patient's condition severe enough that it prevents them from completing an assignment, class work or exam? YES / NO

My assessment of the patient's condition was based on:
 (tick the applicable box)

<input checked="" type="checkbox"/>	An examination of the patient	<input checked="" type="checkbox"/>	Information provided by the patient	<input checked="" type="checkbox"/>	I am unable to assess how the illness would affect the patient's capacity to complete coursework.
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Please state the nature of the problem/illness/difficulty experienced by the patient over the stated period, within the limits of patient confidentiality.

Practitioner's Signature		Date	D D / M M / Y Y Y Y			
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All sections of the form must be completed. Certificates from Traditional Medical Practitioners or family members will not be accepted.

ACPE Office Use Only							
<input checked="" type="checkbox"/>	Medical certificate approved	<input checked="" type="checkbox"/>	Medical certificate not approved	Staff Initial		Date	