REQUEST FOR CONSIDERATION FORM

STUDENT’S NAME ____________________________________________________________

LANGUAGE ___________________________________________ CLASS ______________

TEACHER’S NAME __________________________________________________________

NATURE OF ASSESSMENT TASK ________________________________________________
(Listening and Responding, Speaking, Reading and Responding, Writing)

DUE DATE OF TASK __________________________________________________________________

DATE THAT TASK WILL BE COMPLETED __________________________________________________________________

REASON FOR ABSENCE __________________________________________________________________
(Provide sufficient information to support your case for consideration to sit for the task or substitute task or to gain an extension)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

MEDICAL CERTIFICATE FROM: __________________________________ (Name of doctor)

OR NATURE OF OTHER INDEPENDENT EVIDENCE

*Complete relevant section overleaf

STUDENT’S SIGNATURE __________________________ DATE ______________

PARENT’S/CAREGIVER’S SIGNATURE __________________________ DATE ______________

TEACHER’S COMMENT ______________________________________

CENTRE EXECUTIVE RECOMMENDATION:

________________________________________________________

COMMUNICATED TO STUDENT AND PARENT/CAREGIVER: __________________________

SUPERVISOR’S SIGNATURE __________________________ DATE ______________
The Saturday School of Community Languages, in line with the BOSTES procedures, advises that students should attend examinations and submit assessment tasks unless it is considered detrimental to their health. Students who are unwell or experience misadventure must seek independent medical advice either immediately before or after each task OR examination AND present this medical certificate to the Centre Supervisor on their first Saturday back at school.

The person completing Section A or B must NOT be related to the student.

Independent evidence of illness – complete Section A.

Independent evidence of misadventure – complete Section B.

**Section A**

**Independent evidence of illness: to be completed by a medical practitioner**

Diagnosis of medical condition:

Date of onset of illness:

Date(s) and time(s) of all consultations / meetings relating to this illness:

Please describe how the student’s condition/symptoms could affect their examination performance. *If the student was unable to attend an examination, it is essential that you provide full details in the space provided or on additional sheet(s) and attach them to the application.*

Any other comments or information which may assist in the assessment of the student’s appeal. *If there is not enough space, please attach additional sheet/s.*

Please note that any fee for providing this report is the responsibility of the student.

Name of doctor or other health professional providing this information:

Profession:

Place of work/organisation:

Address: Contact Phone: Date:

**Section B**

**Independent evidence of misadventure: to be completed by a relevant person such as a police officer or a counsellor**

Date of misadventure event:

Were you a witness to the event? Yes / No If No, how did you obtain the evidence you are providing?

Are you known to the student? Yes / No If Yes, nature of relationship:

Description of event:

Name: Profession: Place of work / organisation:

Address: Contact Phone: Date: