Application Form

Name: ___________________________ Phone No: ___________________________
Course / Subject: ___________________________
Teacher: ___________________________ Class: ___________________________
Task: ___________________________
Due Date: _____/ _____/ _____ M / T / W / T / F (please circle)
Reason why you are applying for Illness / Misadventure: ___________________________

______________________________
______________________________
______________________________
______________________________
______________________________

Student signature: ___________________________ Date: _____/ _____/ _____
Supporting Documentation: YES / NO
(please circle) Eg. Doctor’s Certificate

How had the reason provided affected the completion of the task? ___________________________

______________________________
______________________________
______________________________

Parent Signature ___________________________ Date: _____/ _____/ _____
Teacher Comment: ___________________________

______________________________
______________________________

Teacher Signature: ___________________________ Date: _____/ _____/ _____
Approval: YES / NO

Explanation: ___________________________

New Submission Date (if appropriate) _____/ _____/ _____
Head Teacher Signature ___________________________ Date: _____/ _____/ _____

Year 10 ROSA - Zero will apply for tasks submitted late. Stage 6 - Zero will apply for tasks submitted late.
Principal Signature ___________________________ Date: _____/ _____/ _____
Alternate Task [] Zero Awarded [] New Submission []
PART A  Independent Evidence of Illness

Diagnosis of Medical condition: ________________________________________________________
Date of onset of illness: _____/ ____/ ____
Date(s) and time(s) of all consultations related to illness ______________________________________

Please describe how the student’s condition / symptoms could impede their performance in the relevant task:
____________________________________________________________________________________
____________________________________________________________________________________

Name of doctor or health care professional ____________________________________________
Profession__________________________ Place of work ________________________________
Address ____________________________________________________________________________
Contact Number________________________ Signed__________________________ Date __________
Service Provider No. ______________________

PART B  Independent Evidence of Misadventure

Date of event causing misadventure__/ ____/ ____
Were you a witness to the event Yes/No
If (NO), how did you obtain the information you are providing? ______________________________
What is your relationship to the student? _____________________________________________
Describe the event ___________________________________________________________________
____________________________________________________________________________________

Name: ____________________________ Profession: __________________________
Contact Number: ___________________ Signed__________________________ Date __________