

Medical Impact Statement

Background

This form is for international students seeking a release from Murdoch University, for the purpose of transfer to another educational institution, on medical grounds.

The student should request that the student's treating practitioner complete this form. The form should be returned to Murdoch University.

Applying for a release does not guarantee that your request will be granted. You must continue to be enrolled at Murdoch University while your application is being assessed.

Who can complete this form?

This form may be completed by any of the following:

- (a) a medical practitioner registered with the *Medical Board of Australia*;
- (b) a psychologist registered with the *Psychology Board of Australia*;
- (c) a medical radiation practitioner registered with the *Medical Radiation Practice Board*;
- (d) a counsellor registered with an Australian professional body for counsellors; or
- (e) the equivalent of any of the above who is accredited/registered in a jurisdiction outside Australia.

It should not be completed by a health practitioner who is a family member of, has a close personal relationship with the student or an employee of the provider the student wishes to transfer to

The form must describe the nature and seriousness of the student's condition so that an assessment of the possible effects of the condition on the student's ability to study at Murdoch University can be made.

Health / Medical Practitioner to complete:

- **Name of Patient:**

- **Patient Date of Birth:**

- **Date(s) on which Student was seen:**

- **Nature of Condition:**

(Please indicate how this will affect the student's ability to study at Murdoch University)

- **Assessment of Severity of Condition:**

Mild Moderate Severe Patient is hospitalised

- **Your Opinion of Likely Effect on Student's capacity to Study at Murdoch University:**

Mild Moderate Severe

- **Your professional opinion of the likely duration of the medical condition impacting the student's capacity to study:**

Short-term (1-4 weeks)

Medium-term (up to 6 months)

Long-term (1 year +)

Signature

By signing this form, I declare that I meet the requirements set out in the "Who Can Complete This Form" section above, and that the information I have provided is based on my professional examination and opinion.

Practitioner name:	
Registration / Provider number:	
Address of Practice:	
Practice telephone number:	
Email:	
Signature:	
Date:	

Student Permission (Student to complete)

By signing this form, I give permission for Murdoch University to contact my health practitioner to verify the information on this form, if needed, and for relevant information to be provided by my health practitioner to Murdoch University.

Student signature:

Date: