Alternative Assessment Arrangements – Formal Assessments

(Written Invigilations / Exams)

Supporting Documentation Form

Students studying with OUA who wish to request special arrangements for formal assessments (Exams and Tests) are required to provide supporting medical documentation outlining details of the specific disability and the functional implications of this disability in a formal assessment environment.

Information must be provided by an appropriate practitioner or health care provider and must be recorded on this form with attached documentation if required. Some Provider Universities require additional documentation and/or forms, contact should be made with Provider Disability Contact officers for documentation requirements.

The original (or a certified copy of the original) completed form and any original (or certified copies of) supporting documentation must be handed or posted to the applicable OUA Provider Disability Contact Officer. Please refer to the relevant OUA Provider for contact details.

Please Note: Students must apply for Alternative Assessment Arrangements with each OUA Provider where they wish to have Alternative Assessment Arrangements applied to the units being studied.

<table>
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<tr>
<th>Student Authority for Provision of Information (to be completed by student)</th>
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OUA ID ____________________________ Provider ID ____________________________

Family Name ____________________________ First name ____________________________

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<tr>
<th>Unit Code</th>
<th>Unit Name</th>
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I hereby authorise the practitioner or health care provider to provide the information below and in any attachments, and I authorise the Disability Officer or Equity Officer to contact the nominated practitioner /health care provider to discuss or clarify these supports if required.

Signature ____________________________ Date ____________________________
To be completed by the Practitioner / Health Care Provider

Name of Disability or Medical Condition

Indicate which category the disability/condition best fits into:

☐ Hearing  ☐ Mobility/Physical  ☐ Vision
☐ Neurological  ☐ Learning  ☐ Medical
☐ Mental Health  ☐ Other _______________________

Please indicate whether this condition is:

☐ Permanent  ☐ Temporary
☐ Improving  ☐ Degenerative
☐ Fluctuating

NB: Where applicable, please indicate the date the condition is expected to be resolved ___/___/_____

List the Functional Impacts of the disability as they apply to this student.
How does the disability or condition impact on the student’s ability to study? E.g. Inability to sit for long periods, fatigue, loss of concentration, medication effects etc. Further information may be attached.

_______________________________________________________________________________________________
___________________________________________________________________________________________

Are there specific recommendations for reasonable adjustments, in response to the functional impacts listed above that would assist this student to enable equal participation relevant to a university learning environment? Please list suggested alternative assessment arrangements: e.g. Ergonomic seating, completing exams nearer to home, enlarged printing etc.

_______________________________________________________________________________________________
_____________________________________________________________________________________________

Please tick the appropriate box or boxes below if you are recommending that extra time be allocated:
Working time  ☐  Resting time  ☐

Practitioner / Health Care Provider Name__________________________________________________________
Practitioner/Health Care Provider Qualifications / Title(e.g.GP, Psychiatrist, Psychologist)_____________________________
Address _______________________________________________________________________________________
Phone ___________________________  Fax ___________________________
Practitioner/Health Care Provider Signature ___________________________  Date ___________________________
Provider Stamp: ___________________________