Charles Sturt University

WORKPLACE LEARNING
FACULTY OF ARTS AND EDUCATION

Professional Experience

Leave of Absence during Placement

Title: First Name: _____ Surname: _____

Student ID Number: _____ Email: _____

School/Service: _____ Faculty at School (if applicable): _____

School/Service Address: _____ Phone Number: _____

Period of Leave

Start Date: _____ End Date: _____ Number of Hours *(if only part day):* ____

Nature of Leave (Compassionate, Sick, Other): _____

Reason for Leave:

Medical Certificate *(Required in all cases of sick leave exceeding 2 days)*

Name of Doctor: _____

Medical Practice: _____

Teacher Education Student Signature: _____ Date: _____

Principal/Director's Comments:

Principal/Director's Name: _____

Principal/Director's Signature: _____ Date: _____

Please return completed form with Medical Certificate via BRIGHTSPACE to your Subject Coordinator