



The Society of Cardiopulmonary Technology (NZ) Incorporated

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APPLICATION FOR AEGROTAT CONSIDERATION

Full name	
Department	
Hospital	
Phone number	
Fax number	
Email address	

1. Reason for request for Aegrotat consideration (please tick one):

Illness (A medical certificate must be attached)

Compassionate (e.g. bereavement)

Other (please explain) _____

2. Give details of the assignment(s) that you are applying for an aegrotat consideration.

Worksheet Number	Worksheet Subject	Due Date

3. Have you previously applied for Aegrotat consideration?

YES / NO

Date:

Supervisors Name and Signature: _____

Applicants Signature: _____ Date: _____

Office Use Only:

Supervisors Signature: Y / N

Aegrotat Mark to be awarded: Y / N Mark = _____