Student details

Please provide the details below (note that all fields must be filled in).

Family name *

First name(s) *

Student Record Number *

Course of study *

Level and mode of Study *
- Undergraduate (Full Time)
- Undergraduate (Part Time)
- Postgraduate Taught (Full Time)
- Postgraduate Taught (Part Time)
- Visiting Student
- Other

Year of study (e.g. 1 or 2 and so on) *

Department/School/Course submitting the request *

Please select

Next Page
PGT Suspension - nature of the request

Please select one option below. You will then be taken to the relevant page of the form to fill in further details.

Please check the relevant option *
- Request to award a higher degree classification even though the candidate has not met the required weighted average
- Request to permit a period of interruption in excess of 24 months
- Other

Nature of the PGT request if not described above

PGT courses affected (please provide course codes) *

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Rationale for the request

Please provide details of the request and any further relevant information (on the next page you will be asked to upload documentary evidence to support the request).

Rationale *

Please provide a detailed description of the rationale for the request for a waiver of regulations.
Evidence in support of the request

Please upload supporting documentation below. Please note that a complete set of documents will be required for consideration by ECA.

Mark grid(s) for this student ONLY with module outcomes

Choose File  No file chosen

Evidence of extenuating circumstances (non ECA requests)

Choose File  No file chosen

Evidence of extenuating circumstances (ECA requests): AQPO will obtain
reacted evidence from Student Admin for the student

☐ I understand AQPO will obtain redacted evidence from Student Admin

If required, please use this box to upload additional evidence of extenuating circumstances

Choose File  No file chosen

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Details of the Member of Staff Submitting the Request

Please provide the details below (note that all fields must be filled in). By signing the name of the Chair of Department Assessment Board/Course Director below, you confirm that this form is being submitted with their knowledge and approval.

**Name of Chair of Department Assessment Board/Course Director** *
First [ ] Last [ ]

**Email address of the member of staff named above** *

**Role of the member of staff named above** *
- Chair of Department Assessment Board
- Course Director
- Other

**Today’s date** *

**Have you consulted your Senior Academic Quality Manager (SAQM) about this request?** *
- Yes
- No

**Date of consultation with Senior Academic Quality Manager (SAQM)**

[Submit]