

Medical Evidence Form

Confidential

Student details:

Forename(s): _____ Surname: _____

Date of Birth: _____

Diagnosis/working diagnosis:

Please include the main symptoms of the condition (especially any that may have an impact on study, e.g. concentration, memory, anxiety).

In your professional opinion:

Does the person named above have an enduring health condition which has or is likely to last for a year or more?
Yes/No

Does this condition have a substantial adverse effect on their day-to-day activities, including study?
Yes/No

Would the person named above benefit from additional arrangements during his/her examinations, e.g. extra time?
Yes/No

Please state what support would be beneficial, if recommending additional time or resting breaks, please specify the amount of time needed.

Signed: _____ Date: _____

Name: _____ Job title: _____

Type of practice or organisation (please circle): Contact details (telephone and email):

- GP Practice
- Primary Care Health Team
- Secondary Care Health Team
- Hospital
- Other (please specify)

Please include your organisation's official stamp. Alternatively, this information could be copied onto headed paper.

As the student can't reclaim any charge made for completing this form from the university, we ask that it be provided free of charge. Thank you.