Medical Evidence Form

This form must be completed by your Medical Practitioner or Health Professional.

Name of Medical Practitioner / Health Professional: **Name and address of Hospital / Clinic / Surgery:** **Telephone number:**	***Please write details below, or use official stamp:***

I certify that I examined Mr/Miss _____ *(Name of Applicant)*

on _____ *(Date/s of consultation)*

1. What is the impact of the disability or medical condition on the student's ability to learn?
(Please note that the information you provide will be treated in the strictest confidence and that you should provide all relevant information with this application. Please explain how it impaired the candidate in their studies)

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Dates of onset and functional resolution of the problem: from _____ to _____

Dates of first consultation regarding this problem: from _____ to _____

Degree of disability/medical condition - Please rate the degree relating to the degree of functional or cognitive impairment at the time of the illness. *(Please mark an **X** in the appropriate box.)*

Mild	Moderate	Severe	Chronic

2. Functional Assessment:
In my opinion, the student's disability or medical condition or circumstances will affect the student in the following tasks:

	Nil	Minor	Moderate	Severe	Unable to assess
Assignments	☐	☐	☐	☐	☐
Practical sessions	☐	☐	☐	☐	☐
Group work	☐	☐	☐	☐	☐
Examinations	☐	☐	☐	☐	☐
Independent study	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

(Please specify) _____

3. Declaration of Medical Practitioner / Health Professional

I consider the above disability / medical condition to be temporary or abating in nature and, as a result, I consider that the applicant was disadvantaged in their studies.

Signature: _____ Date: _____