**Mitigating Circumstances: Medical Evidence Form**

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University Regulations require that claims of extenuating circumstances of a medical nature must be supported by reliable independent documentary medical evidence.

**To be completed by the student:**

|  |  |  |  |
| --- | --- | --- | --- |
| Full name  |  | Date of Birth |  |
| Please confirm in the box below the illness/ medical condition/ symptoms that you wish to be considered as mitigation by the University. |
| Please confirm the dates in which you experienced the medical condition/ illness/ medical symptoms. |
| **Consent Declaration:** * I give my consent for the Medical Practitioner listed below to provide the information required in this form. [ ]  **Yes** [ ]  **No**
* I give my consent for the University to process the information in this form in relation to my appeal. [ ]  **Yes** [ ]  **No**
 |
| **Student Signature** |  | **Date** |  |

**To be completed by the Medical Practitioner:**

|  |
| --- |
| Did you examine the above-named student on or around the time they experienced the medical condition/illness/medical symptoms indicated above? [ ]  **Yes** [ ]  **No**  |
| If yes, what date(s) did you examine the student? |  |
| In your professional opinion, would the medical condition/illness/medical symptoms indicated above have prevented the student from undertaking coursework/assessments or engaging effectively with their studies on the dates specified? [ ]  **Yes** [ ]  **No** **Please state the dates between which the student was not fit to be assessed/ engage with their studies:****From: To:**  |
| **\*Where necessary, please add any further advice relating to this matter here.** |
| **Medical Practitioner Name** \*(please print)  |  | **Position Held** |  |
| **Practitioner Signature** |  | **Date:** |  |
| Please endorse here with an official stamp  |