**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 | | | | | |