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| **MEDICAL EVIDENCE FORM** |  |
| **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 named 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 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:**  |  | **Position Held:** |  |
| **Practitioner Signature:** |  | **Date:** |  |
| **Please endorse here with an official stamp or enter the name and address of the medical practice.** |
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