UNIVERSITY HEALTH SERVICE

REQUEST FOR DISABILITY REPORT FOR DSA

Please complete this form and submit it to reception with your payment.
You **do not** need to make an appointment with a doctor to submit the form.

1.	Surname/family name	
2.	Forename(s)	
3.	Date of birth	
4.	Current address	
5.	Contact telephone number	
6.	Please tell us what medical problem(s) you are using as the grounds for your application	
7.	Please describe the impact of your disability on your studies	
8.	Please give the time period over which your studies have been adversely affected	
9.	Declaration	I consent to information being released from my confidential medical record to the Enabling Services for my application for DSA
10.	Release	☐ I wish to see this report before it is despatched, please advise me when it is ready and I will collect it ☐ I do not wish to see this report before it is despatched, please send it direct to the Enabling Services
11.	Fee	I agree to pay the applicable fee for the provision of this report. (Work will not begin on the report until the fee is paid.)
12.	Applicant's signature	
13.	Date	D D / M M / 2 0 Y Y