# REQUEST FOR SPECIAL CONSIDERATIONS MEDICAL REPORT

UNIVERSITY HEALTH SERVICE

**When to use this form:**

The School may require a medical report from your GP if ***ALL*** of the criteria below apply:

- You experienced ill health during the course of the academic year
  **AND**
- Your ill health required medical attention
  **AND**
- You have been advised by your tutor that the School Special Consideration Board may recommend reconsideration of the outcome of your examination or work in light of this illness.

| **PART A - TO BE COMPLETED BY STUDENT** | |
|---|---|
| 1. **Name** | |
| 2. **Date of Birth** | D D / M M / Y Y Y Y |
| 3. **Name of your GP** | Dr |
| 4. **Nature of illness** | |
| 5. **Dates of illness** | |
| 6. **Reviewing the report (please tick)** | ☐ I **DO WISH** to see the report before it is despatched<br>☐ I **DO NOT** wish to see the report before its despatch |
| 7. **Declaration by student** | • I agree to the release of medical information from records held by my GP<br>• I understand that a fee is payable for the medical report and I am willing to pay the required fee<br>• I understand that a false claim of ill health used to influence the assessment of my University work will result in the imposition of penalties which may include termination of my programme. |
| 8. **Signature of student & date of signing** | D D / M M / 2 0 Y Y |
| **PART B - TO BE COMPLETED BY SCHOOL** | |
| 9. **Request from School** | • I have been informed by the student above that they have consulted you in relation to the illness named above<br>• I wish to request a medical report relating to this illness<br>• I have discussed with the student whether the report may have the potential to lead to a reconsideration of the outcome of assessment of work and/or justify extended deadlines for completion of work |
| 10. **Name of Tutor** ***(BLOCK CAPITALS PLEASE)*** | *Title* \| *Forename* \| *Surname* |
| 11. **School/Department** | |
| 12. **Position** | |
| 13. **Address to send report to** | |
| 14. **Signature of Tutor/School & date of signing** | D D / M M / 2 0 Y Y |

PLEASE RETURN THIS FORM TO RECEPTION WITH THE REPORT WRITING FEE

YOU **DO NOT** NEED TO SEE A DOCTOR TO DISCUSS THIS FORM

OFFICE USE ONLY - EMIS No