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| **UNIVERSITY OF SOUTHAMPTON MEDICAL EVIDENCE REQUEST** |

**If you are unsure which route to take and therefore what evidence is required, we recommend you discuss this with Student Disability and Inclusion in the first instance**

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| **REPORT REQUEST** | |
| **Why are you requesting a report?** | |
|  | Reasonable adjustments (including for exams) from Student Disability and Inclusion ONLY |
|  | Special Considerations (when self-certification is not possible) |
|  | DSA application AND reasonable adjustments (including for exams) from Student Disability and Inclusion (★SEE NOTE BELOW) |
|  | DSA application ONLY (★SEE NOTE BELOW) |
|  | Other – ***please give FULL details:*** |
| ★PLEASE NOTE: Please complete the information below (page 1 only) and attach the DSA evidence form which is available under the heading ‘Proving you’re eligible’ at  <https://www.gov.uk/disabled-students-allowances-dsas/eligibility>. This will be used by your doctor to provide your medical evidence. | |

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| **PATIENT INFORMATION** | | |
| Name: | Telephone: | |
| Date of birth: | Doctor’s Name: | |
| Address: | Name & Address of GP Practice: | |
| Nature of illness: | Date from: | Date to: |
| Please give us a brief description of impact of this illness on studies for example on memory or motivational difficulties, concentration, anxiety or paranoia, mobility, daily living, etc: | | |

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| **DECLARATION** | |
| * I understand that **a fee is payable** for the medical report as this is not an NHS service. I am willing to pay the required fee. * I **agree to the release** of medical information from records held by my GP. * I understand that completion time for reports is **10 working days** from the date the form is received at the Surgery. * I understand that if I wish to see the report before it is sent, **I must do so within 21 days** otherwise the report will be sent. * 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. | |
| Signature of student: | Date of signing: |
| **YOU MUST SIGN THIS BY HAND, DO NOT PROVIDE AN IMAGE OR ELECTRONIC SIGNATURE** |

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| **DESTINATION** | |
| **What do you wish to happen to the completed report?** | |
|  | (A) I wish to collect the completed report from reception (please do not complete the recipient section below) |
|  | (B) Please send the completed form to the person indicated below (please complete the recipient section below) |

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| **RECIPIENT (if option B selected only)** | | |
| **Before your report is sent to the person below, do you wish to see it first?** | | |
|  | I wish to see it & will do so within 21 days of completion (please note, the report will be sent after 21 days if you do not view it) | |
|  | I do not wish to see it, please send it the report to the person indicated below | |
| Please give the name an email address or postal address of the person you wish us to send the report to: | | |
| Name: | |  |
| Email: | |  |
| Postal address: | |  |