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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.
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| 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: |       |