Medical Evidence Form

This form must be completed by your Medical Practitioner or Health Professional.

Name of Medical Practitioner / Health Professional:

Name and address of Hospital / Clinic / Surgery:

Telephone number:

Please write details below, or use official stamp:

I certify that I examined Mr/Miss ____________________________________________ (Name of Applicant)

on _____________________________________________ (Date/s of consultation)

1. What is the impact of the disability or medical condition on the student’s ability to learn?
(Please note that the information you provide will be treated in the strictest confidence and that you should provide all relevant information with this application. Please explain how it impaired the candidate in their studies.)

____________________________________________________________________________________
____________________________________________________________________________________
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____________________________________________________________________________________
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____________________________________________________________________________________
____________________________________________________________________________________

Dates of onset and functional resolution of the problem: from ______ to ______

Dates of first consultation regarding this problem: from ______ to ______

Degree of disability/medical condition - Please rate the degree relating to the degree of functional or cognitive impairment at the time of the illness. (Please mark an X in the appropriate box.)

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Chronic</th>
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2. Functional Assessment:
In my opinion, the student’s disability or medical condition or circumstances will affect the student in the following tasks:

Assignments
Practical sessions
Group work
Examinations
Independent study
Other
(Please specify) ____________________________________________

<table>
<thead>
<tr>
<th>Nil</th>
<th>Minor</th>
<th>Moderate</th>
<th>Severe</th>
<th>Unable to assess</th>
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3. Declaration of Medical Practitioner / Health Professional
I consider the above disability / medical condition to be temporary or abating in nature and, as a result, I consider that the applicant was disadvantaged in their studies.

Signature: ___________________________ Date: ___________________________