**Additional Criterion 5**

**Disability or medical condition that impacts on study**

Student’s Name:__________________________________________

**Step 1**

Describe the nature of the disability or medical condition you experienced during Year 11 and state whether the disability or condition is now over or abating or is being managed effectively. For example;

<table>
<thead>
<tr>
<th>Medical</th>
<th>Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Dyslexia</td>
</tr>
<tr>
<td>Asthma</td>
<td>ADHD/ADD</td>
</tr>
<tr>
<td>Glandular Fever</td>
<td>Mental Health Condition</td>
</tr>
</tbody>
</table>

_________________________________________________________________________________
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Step 2
What impact did your disability or medical condition have on your studies (or equivalent)?
(Place an X in the appropriate box.)

Note: You must provide evidence to support your claim and that evidence must make clear the impact on your studies. The University may re-assess your claim based on the supporting evidence.

- I was severely incapacitated
- I was moderately incapacitated due to recurring symptoms
- I had occasional disruptions to my studies
- Impact was relatively minor

Comments to elaborate further (If required):
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Step 3
How long has your disability or medical condition affected your study? (Place an X in the appropriate box.)

- For more than 2 years
- For between 1 and 2 years
- For 6 months to 1 year
- For less than 6 months

Student’s Signature:_________________________________________
Date:_________________________________________

Step 4
Complete the Medical Evidence Form below and attach any additional documents you may have from Medical Practitioners or Health Professionals to confirm your claims.

This form should be completed and returned to the applicant OR alternatively it may be posted directly to:

CONFIDENTIAL
The University of Western Australia
Student Support Services
Attention: Dr Helen CD McCarthy
Fairway UWA Coordinator
M 302
35 Stirling Highway
CRAWLEY WA 6009
Fairway UWA 2011
Medical Evidence Form

This form must be completed by your Medical Practitioner or Health Professional in relation to Criterion 5.

| Name of Medical Practitioner / Health Professional: | Please write details below, or use official stamp: |
| Name and address of Hospital / Clinic / Surgery: |
| Telephone number: |

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)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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

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

Degree of disability/medicate condition - Please rate the degree of functional or cognate 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>
</tr>
</thead>
</table>

2. Functional Assessment:
In my opinion the student’s disability or medical condition or circumstances will affect the student in the following tasks:

Assignments □ Nil □ Minor □ Moderate □ Severe □ Unable to assess
Practical sessions □ □ □ □ □
Group work □ □ □ □ □
Examinations □ □ □ □ □
Independent study □ □ □ □ □
Other (Please specify) □ □ □ □ □

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: ____________________________