

# Medical Group

Practice Stamp

## **Medical Confirmation Form (supports the Extenuating Circumstances Form ("ECF"))**

Extenuating Circumstances are defined as circumstances which are outside the control of the student and negatively affect performance and which can be supported by appropriate evidence. The Medical Confirmation Form is the evidence base for the student to have their extenuating circumstances taken into account by the University. Please could the doctor/nurse complete the form and, to verify authenticity, add your Practice stamp to the top right of the form.

### ***PART A to be completed by the student***

This form should be used when you need to provide evidence to the University of an illness or an inability to perform. Please complete Part A, sign and take to your Medical Practice/Health Centre. You may be asked to pay a fee to the Medical Practice/Health Centre for this service. Evidence must be received by the University within 5 working days of the submission of your ECF.

Name:	Student No:
Date of Birth:	Phone number:
Confirm the overall period of time when you have been affected by your condition or situation:	
From:	To:
Confirm the assessments with submission deadlines or examination dates affected by your condition or situation:	
Briefly describe the nature of your problem and any treatment you have had and how your work has been affected:	
Which Doctor(s) and/or Nurse did you see and on what date(s)?	
<b>I give my consent for the Medical Practice to disclose information from my confidential medical records which is relevant to this request both to the relevant officer(s) of the University and to the relevant Examiners</b>	
Signature:	Date:

### ***PART B To be completed by the Doctor or nurse of the Medical Practice***

I confirm that the above dates correlate with the information held by the Medical Practice/Health Centre	Yes <input type="checkbox"/>	No <input type="checkbox"/>
What is the condition that the student is suffering from?		
From the information on the medical record, is this condition likely to impact the student's ability to engage in study and / or assessment activities for the time period specified by the student above?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comment (if appropriate, include when you consider the student may be fit to return to studies/examinations):		
Print Name:	Signed:	Date:

