

Confirmation of illness affecting assessment

STUDENT'S PERSONAL DETAILS	
Name	
Date of Birth	
Programme of Study	
Department	
Student number	

To the doctor/nurse

This completed form will be used as evidence in a claim for exceptional circumstances affecting assessment because the student believes their ability to study/prepare/participate in their assessment(s) /exam(s) has been impaired. Please give details of your diagnosis of this student's condition and how it has prevented them from studying effectively. This diagnosis should be the result of a face-to-face consultation.

What is this student suffering from?	Does this condition prevent this student from engaging in any study activity?
	Yes / No <i>(delete as appropriate)</i>
	If some limited activities are possible (e.g. reading, studying for short periods, email) please specify,
Dates affected	To: _____ From: _____

Signed:

Doctor / Nurse

Name of Doctor/Nurse *(please print)*

Date of consultation:

Date form completed:

Practitioner address and telephone number

I agree that a copy of this form may be forwarded to Student Support Services Yes

No

Student's signature