

**SHU Disability Evidence Form**

Disabled Student Support

Level 5, Owen Building

Sheffield Hallam University

Howard Street

Sheffield S1 1WB

Tel: 0114 225 3964

Email: disability-support@shu.ac.uk

Dear Sir/Madam,

**Re: Student name:**

 **Date of birth:**

 **Student address:**

We are making this request on behalf of the above named student who is in the process of applying for support for their studies. In order for support to be put in place, we need evidence from a recognised medical professional that the student has a disability that will impact on their studies. We would be grateful if you could please complete the attached form and return it directly to the student.

Yours faithfully,

Disabled Student Support

**Student's Consent:**

I give consent for relevant confidential medical and/or personal information to be released to the Disabled Student Support Service at Sheffield Hallam University.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please note that where a charge has to be made for the completion of this form, any request for payment should be made directly to the student.**

**Student Name: Date of birth:**

|  |  |
| --- | --- |
| **Organisation stamp (where available) and/or complement slip or headed paper attached**Evidence must be stamped or on headed paper |  |
| **Organisation Address:** |  |

|  |  |
| --- | --- |
| **Diagnosis / working diagnosis:**If it is not possible to give a diagnosis or working diagnosis please explain why |  |
| **Has this condition lasted, or it is likely to last for 12 months or more?** (answer essential) | Yes No |
| **Impact on study and day to day activities** (please tick all that apply) |
| Attendance |  | Group Work |  | Anxiety |  |
| Meeting deadlines |  | Note taking |  | Concentration |  |
| Organisation and Planning |  | Reading and research |  | Fatigue |  |
| Placement |  | Exams |  | Motivation |  |
| Pain |  | Mobility |  | Memory |  |
| Other impact/additional information: |
| **Medical/Mental Health Professional Details** |
| Job Title: |  |
| The nature of your professional involvement with the student (if not apparent from your job title) |  |
| **Organisation Type** |
| GP Practice |  | Secondary Care Mental Health Team (including EIP, Crisis Teams, Community Mental Health teams etc.) |  |
| Primary Care Mental Health Team (including IAPT services) |  | Other (please specify): |

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (PLEASE USE BLOCK CAPITALS)**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_**