SHU Disability Evidence Form

Tel: 0114 225 3964
Email: disability-support@shu.ac.uk

Students:

When this form has been completed by your medical professional (e.g. GP, consultant, psychologist), please scan it, or take a photograph of it on your phone and either:

1. Upload it to your DSS registration at https://msr.shu.ac.uk/
2. Or Email it to disability-support@shu.ac.uk

We strongly advise you to keep any hard copies of your evidence somewhere safe in case you need them again.

Student 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 DD/MM/YYYY:

Medical Professionals:

Re: Student name:

Date of birth
DD/MM/YYYY:

Student Address:

We are making this request on behalf of the abovenamed 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, or if possible, to email it to us directly at disability-support@shu.ac.uk.

Yours faithfully,

Disabled Student Support

Please note that where a charge is 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):	

Full Name PLEASE USE BLOCK CAPITALS

Certificate or registration number (GMC, HCPC, NMC)

Signature

Date