# **Disability Evidence Form**

**ESLSCA University Disability Support Registration Form**

This form is for applicants and students at ESLSCA University to provide information about any disability(s), so that we can implement appropriate support services. You have received this form because you have informed ESLSCA University of a disability.

The definition of disability includes mental or physical health conditions, long-term health conditions, and specific learning difficulties.

**Form Submission Guidelines**

* You need to complete this form only once. If you have previously submitted this form, please do not complete it again.
* If you wish to make changes to previously submitted information, contact us at …………..

**Eligibility to Complete This Form:**

To complete this form, you must meet the following criteria:

* You are accepted at ESLSCA university.
* You are a registered student at ESLSCA University
* AND you have a disability.
* AND/OR you have previously received support such as exam accommodations

# **What this form is used for**: In order for ESLCA University to provide you with support, adjustments, and exam arrangements during your studies, we need a medical professional to provide information about your disability. This could be from your GP, Consultant, or another medical professional.

# **What you need to do**:

# Complete your details in Section 1 of this form.

# Give this form to the medical professional so that they can complete the rest of the form and sign the declaration.

# Either you or the medical professional must then return this form to …………. at ESLCA University. You can do this in the following ways:

# By email to .........@eslca.edu

# By bringing the form to …………. office

# If you need further advice on completing this form or about disability evidence, please contact Disability …….. by email at ........@eslca.edu, by phone at [insert phone number here], or in person.

# Section 1: Personal Details

|  |  |
| --- | --- |
| **Student ID Number** |  |
| **First Name** |  |
| **Last Name** |  |
| **Date of Birth** |  |

**Now give this form to the medical professional**

# Section 2: Medical Professional Details

|  |  |  |
| --- | --- | --- |
| **Full Name** |  | |
| **Job title** |  | |
| **Are you medically qualified to diagnose the student’s disability or medical condition?** | | Yes  No |

|  |  |
| --- | --- |
| **Contact Number** |  |
| **Practice or organisation stamp (required).** |  |

# Section 3: About the student’s disability

**Using your professional judgement, please answer the following questions:**

|  |  |
| --- | --- |
| Does the student have a physical, sensory or mental health disability which has a substantial adverse effect on their ability to carry out **typical daily activities**, including activities relating to **studying**? If yes, please give details in “other information”. | Yes  No |
| Is this considered **‘long term’**, i.e. has lasted, or is likely to last for 12 months or more, or for the rest of the student’s life? | Yes  No |
| Is this disability, or the symptoms of it, likely to **fluctuate** over time? If yes, please provide further details below in “other information”. | Yes  No |
| Will this disability affect **going to** campus? If yes, please provide further details below in “other information”. | Yes  No |
| Will this disability affect **mobility around** campus (e.g. moving between teaching venues)? If yes, please provide further details below in “other information”. | Yes  No |
| Will this **only** affect the student in **examinations**, and not in the rest of their studies or daily activities? (e.g. exam anxiety, difficulty with extensive handwriting). If yes, please provide further details below in “other information”. | Yes  No |

|  |  |
| --- | --- |
| **Please confirm the diagnosis** |  |
| **Date of diagnosis or last assessment** |  |
| **Other information/impact**  (continue in the box at the end of the form if required) |  |

# Section 4: Medical professional declaration

Please sign and date below to confirm that, to the best of your knowledge, the information you’ve provided is true and complete.

|  |  |
| --- | --- |
| **Medical professional signature** | **Date** |

**Additional information (use if required)**

**Please give this form back to the student or return to the University**