

University Medical Group

University of Reading Medical Practice
9 Northcourt Avenue
Reading RG2 7HE

Whitley Villa Surgery
1 Christchurch Road
Reading RG2 7AB

T: +44 (0)1189874551
F: +44 (0)1189758392

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F: +44 (0)1189758392

www.readinguniversitymedicalpractice.nhs.uk

Medical Confirmation Form (supports ECF)

This form should be used when you need to provide evidence to the University of an illness or inability to perform. Please complete part A, sign and take to Reception at the Medical Practice. You will be asked to pay a £10 fee and will usually be able to collect the completed form in 5 working days.

Please ensure that you receive a receipt for your payment.

PART A to be completed by the student

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:
Describe the nature of your problem and how it has affected your work:	
Which Doctor(s) and/or Nurse did you see and on what date?	
I give my consent for the University Medical Practice to disclose information from my confidential medical records which is relevant to this request both to the relevant officer of the University and to the relevant Examiners	
Signature:	Date:

PART B To be completed by the Doctor or nurse

I confirm that there is no significant disparity between the students account of his/her problem as described above and his/her medical record	Yes <input type="checkbox"/> No <input type="checkbox"/>
Additional comments from the Doctor or Nurse:	
Signed:	Date