University of Reading Medical Practice
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Medical Group

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:	
Confirm the assessments with submission deadlines or examination dates affected by your condition or situation:	
Briefly describe the nature of your problem and any treatment you have had and how your work has been affected:	
Which Doctor(s) and/or Nurse did you see and on what date(s)?	
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 the above dates correlate with the information held by the health centre	Yes □ No □
What is the condition that the student is suffering from?	
From the information on the medical record, is this condition likely to impact the student's ability to engage in study and / or assessment activities for the time period specified by the student above?	Yes □ No □
Comment (if appropriate, include when you consider the student may be fit to return to studies/examinations):	
Signed:	**Date:**