



Disability Evidence Form

If you require this form in an alternative format, please do not hesitate to get in touch by emailing disability@chester.ac.uk.

Definition of a disability

You're disabled under the Equality Act 2010 if you have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities.

Section 1 – Personal Details (Student to complete)

1.1 Customer Reference Number
(Funding Body) (If known)

1.2 University ID Number
(University of Chester) (If known)

1.3 Personal details

Title

Mr Mrs Miss Ms

Forename(s)

Surname

Date of birth

DAY MONTH YEAR

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Section 2 – Medical Professional Details (Medical Professional to complete)

To support the student's needs, we need you to give us information about the nature of the student's disability. Complete the rest of the form, read, sign and date the declaration, then pass the form back to the student.

2.1 Your details

Full name

Job title

Certificate or registration number (GMC, HPC, NMC)

2.2 Practice or organisation details

Where possible use your practice or organisation's stamp.

Stamp Here

Type of practice or organisation

- GP Practice
- Primary Care Team
- Secondary Care Team
- Hospital
- Other (give details below)

Name of practice or organisation

Address

Contact number

2.3 What is your professional involvement with the student?

You only need to give details if this isn't apparent from your job title.

Section 3 – About the Students Disability (Medical Professional to complete)

In your professional opinion, complete the following questions about the student.

3.1 Does the student have a physical, sensory or mental disability which has a substantial* and long term adverse effect on their ability to carry out normal day-to-day activities (including education)?

To be considered long term, the effect of the disability must have lasted or be likely to last at least 12 months or for the rest of the student’s life.

*more than minor or trivial.

- No
- Yes - give details

3.2 Does the condition necessitate specific accommodation requirements?

Please note that this should not be due to a preference, but due to a disability related need.

- No
- Yes – give details

3.3 Diagnosis / working diagnosis (including any relevant dates)

If it’s not possible to give either, explain why.

Date of diagnosis

DAY MONTH YEAR

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Section 4 – Medical Professional Declaration (Medical Professional to complete)

Medical professional signature

Today's date

DAY MONTH YEAR

X

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Sign and date below to confirm that to the best of your knowledge the information you've provided is true and correct.