MORLING COLLEGE

Section II: Medical Practitioner/Health Care Provider Supporting Documentation

Please ask your Medical Practitioner/Health Care Provider to complete this form

Nature of Disability or Medical Condition
Please indicate which category the student's disability/condition best fits into

☐Hearing ☐Mobility/Physical ☐Vision ☐Neurological ☐Learning ☐ Mental Health ☐Medical

☐Other (please indicate): _____

Please indicate whether the student's disability/condition is

☐Permanent/Chronic ☐Temporary ☐Improving ☐Degenerative ☐Intermittent

Please indicate whether the management of the student's disability/condition is dependent on medication

☐ No ☐Yes (please provide details): _____

If applicable, please indicate when this condition is expected to no longer impact the student's study: _____

Implications for study
Please indicate how the student's disability/condition impacts their ability to study (e.g. inability to sit for long periods, medical effects, reading/comprehension speed). If necessary, please attach further information.

_____

_____

_____

_____

Please indicate your recommendation/s for special consideration. If applicable, please list any suggested alternative assessment arrangements.

☐No special consideration is needed
☐Extra time to complete assignments ☐ Enlarged print or different coloured paper ☐Provision of a standing study area
☐Extra time to complete examinations ☐ Writer for exams ☐Reader for exams ☐Use of a computer for exams
If extra time in an exam is given should this time be used ☐ for a rest break ☐as an extension of their writing time
☐ Other support (please indicate):

_____

_____

Practitioner details

Practitioner's Name: _____

Practitioner's Qualifications/Title (e.g. GP, Psychologist, Specialist): _____

Contact Details (phone or email): _____

Practitioner's Signature: _____ **Date:** _____