UAC Application Number:

Applicant Name:

Applicant Address:

SAMPLE ONLY: DO NOT COMPLETE THIS FORM

Medical impact statement

1. List the condition/disability affecting the applicant.

2. How long has the applicant been affected by the long-term medical condition/disability?

   ☐ Less than 6 months ☐ 6-11 months ☐ 1-2 years ☐ More than 2 years

3. Indicate the impact of the applicant's circumstances on their educational performance by ticking the appropriate box.

   ☐ Not at all ☐ Slight ☐ Moderate ☐ Considerable ☐ A great deal

4. Describe the nature and duration of any treatment for the medical condition/disability.

UAC Application Number:

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Applicant Address:

SAMPLE ONLY: DO NOT COMPLETE THIS FORM

5. Describe the ways in which the applicant's long-term medical condition/disability and/or treatment has affected their educational performance.

Details of person completing the medical impact statement

Name

Position/occupation

Reg/Provider No

Name of organisation (if applicable)

Daytime telephone

Alternate telephone

Signature (Name)

☐ I declare that I have provided true and complete information. (For information about UAC's procedures for processing applications suspected of being untrue or incomplete, read 'Applicant responsibilities'.)

Date