

**Request for Reasonable Adjustment**

**Students with a temporary medical condition or illness**

This form should be completed by all students requiring Additional Learning Support and/or Examination Access arrangements for temporary medical conditions or illnesses. Students with a non-temporary, medically diagnosed condition or disability and students with Specific Learning Difficulties (eg: Dyslexia, Dyspraxia, ADHD and Asperger’s Syndrome) should not use this form. Those students should contact the Student Support Administration Manager for appropriate guidance and forms for applying for Special Examination Arrangements.

**Section A: to be completed by the student**

|  |  |
| --- | --- |
| Student Name | Click here to enter text. |
| Student ID Number | Click here to enter text. |
| Programme of Study | Click here to enter text. |
| Programme Start Date | Click here to enter text. |
| Year of Study | Choose an item. |
| Contact Telephone Number | Click here to enter text. |
| Contact email address (home) | Click here to enter text. |
| Contact email address (college) | Click here to enter text. |
| Have you applied for Disabled Student Allowance | Choose an item. |
| If yes, please indicate whether granted or not and, if granted, send a copy of the Assessor’s Report with this form | Choose an item. |

**Consent to disclose information regarding additional learning needs**

**Data Protection Act 1998**: The data collected on this form will be used for monitoring and statutory reporting purposes as required by the College, its validating partners and other regulatory bodies, and will be stored securely. For more details, please see the College’s Data Protection Notice and the Data Collection - Fair Processing Notice, both of which are available on the College’s website.

Please tick the box below if, in addition, you consent to disclosure of the information as authorised below. If you do not give consent it may not be possible to provide you with the support or reasonable adjustments you need.

[ ]  I agree that the Student Support Administration Manager and the relevant academic and administrative support staff may exchange information about my disability or additional learning needs where this is necessary to make sure I get the help I need.

|  |  |
| --- | --- |
| Signed (typed name is sufficient) | Click here to enter text. |
| Dated | Click here to enter a date. |

**Please ask your GP or other Qualified Medical Practitioner to complete Section B.**

**Section B: To be completed by a Qualified Medical Practitioner**

|  |  |
| --- | --- |
| Student Enter student name.has been suffering from: | Enter temporary condition or illness |
| Since the following date | Click here to enter a date. |
| And is expected to suffer from this condition/illness until approximately the following date | Click here to enter a date. |
| This condition is likely to affect this student’s studies in the following manner: | Click here to enter text. |
| Please indicate the additional learning support arrangements that you feel are appropriate to reduce the effect of the student’s condition during his/her studies.  | Click here to enter text. |
| This condition is likely to affect this student’s performance in examinations in the following manner: | Click here to enter text. |
| Do you feel that the student would be adequately assisted during examinations by being allocated the standard special arrangements for their condition detailed in the attached guidelines?  | Choose an item. |
| If you answered “no” (or if the student’s condition does not appear in the standard guidelines) please indicate alternative arrangements below. See note below\* before completing this section |
| Extra time in examinations  | Choose an item. |
| How many minutes per hour | Click here to enter text. |
| Use of a computer | Choose an item. |
| Rest breaks | Choose an item. |
| How many minutes per hour | Click here to enter text. |
| Other – please specify | Click here to enter text. |

**Please note\***

Special arrangements should only compensate for the candidate’s disability and not relatively disadvantage other candidates. In order to ensure that comparable consideration may be given to each request for Special Examination Arrangements, the College reserves the right to consult its own medical officer for additional or different arrangements requested.

**Note to Medical Practitioner:** Please print this form, sign, date, stamp and return to the student.

|  |  |  |
| --- | --- | --- |
| **Name of Medical Practitioner:** |  | **Please Validate with your official stamp** |
| **Address** |  |
| **Signed:** |  |
| **Date :** |  |

**Note to student:**

**Please return this form either by scanning it and emailing to** **studentservices@pearsoncollege.com** **or deliver the hard copy to the Student Services Office or the Student Services Post Box at your campus.**

