## MTU Cork campus Disability Support Service

## Evidence of a Disability Form 2023/24

As part of applying for DSS supports, the DSS requires a student to provide evidence of disability to conduct a needs assessment – this is usually in the form of documents.

**MTU Cork campus students who are NOT able to provide evidence, such as a diagnosis report or letter/ statement from previous education confirming educational supports, should submit** **this completed Evidence of Disability Form instead.**

## This form should be completed for a student by a GP / Health Professional / Specialist who is supporting the student around their disability or learning difference or significant ongoing health condition. The form needs to be signed and stamped/accompanied by headed paper.

## The student should then send a copy to dssCork@mtu.ie

If you have any questions about your evidence of disability or completing this form please contact the DSS at dssCork@mtu.ie

|  |
| --- |
| Evidence of a Disability FormInstructions for Completion:* Applicants must arrange for this form to be completed on their behalf by one of the following:

a GP / Health Professional / Specialist must complete this form. * This form must be signed and stamped/ accompanied by headed paper.

**Please complete ALL sections below in TYPE or BLOCK capitals:** |
| **1** | **Student/Student Details**  |
|

|  |
| --- |
| Name of student:  |
| Date of Birth: |
| Phone Number:  |
| Student Number: |

 |
| **2** | **GP/ Health Professional/Specialist**  |
|

|  |
| --- |
| Name, Title of GP/Health Professional/Specialist:  |
| Address:  |
| Phone (including area code): |
| Position/Professional Credentials:  |
| Date of Report:  |

 |
| **The GP/ Health professional / Specialist should now complete sections 3-7 as appropriate.** |

|  |  |
| --- | --- |
| **3** | **Disability Information (to be completed by the GP/ health professional/specialist)** |
| **In my opinion, the student presents as being impacted by the following disability type (please tick)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ADD/ADHD  |  | Autism Spectrum  |  | Blind/visual impairment |  |
| Deaf/Hard of Hearing  |  | DCD/Dyspraxia/Dysgraphia  |  | Mental Health Condition |  |
| Neurological Condition  |  | Physical Disability/Mobility  |  | Significant ongoing illness |  |
| Specific Learning Difficulty (dyslexia/ dyscalculia) |  | Speech and Language Communication Disorder  |  | Other |  |

|  |
| --- |
| **Please outline details of the disability/ learning difference /significant ongoing health condition that the student presents as being impacted by:** |
|  |
| **Date of onset of above impact (if relevant):** |  |

|  |  |  |
| --- | --- | --- |
| **Has the student been referred to a Consultant or Expert Specialist for a diagnosis?**  | Yes  | No  |
| **If so, please provide the date of referral:** |  |
|  |  |

 |
| **4** | **In your opinion, please briefly describe the anticipated duration or course of the condition and indicate if it will remain static, may have periods of relapse/remission, or may deteriorate.** |
|

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Ongoing/Permanent |  | Temporary |  | Fluctuating |  | Relapse/Remit  |  |

  |
| **5** | **In your opinion, how does the reported impact of the disability/ learning difference/significant ongoing health condition impact on the students’ ability to study and participate (example, fatigue, memory, concentration, pain, etc.)?** |
|  |
| **6** | **Please describe any measures (if any) currently being taken to treat the reported impact of the disability/ learning difference/significant ongoing health condition (e.g., medication, therapy).** |
|  |

|  |  |
| --- | --- |
| **7** | **The GP/Health Professional/Specialist must complete the details below:**  |
| Signature. GP /Health Professional/Specialist  DATE: ­­\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ IMC Number:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

Name of GP/Heath Professional/Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Official Stamp:** This form must be signed by the professional who completed the form. In addition, it should be stamped or accompanied by a signed business card or headed paper. |  |

 |