## 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](mailto: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](mailto:dssCork@mtu.ie)

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| 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.** | |

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| **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.)?** |
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| **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).** |
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| **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. |  | | |