**University of Warwick Health Centre**

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| **Medical Certificate for Conditions affecting Study and/or Examinations**  Sections 1 & 2 should be completed by the student before emailing the form to the Health Centre.  Email address: [**uniadmin.m86029@nhs.net**](mailto:uniadmin.m86029@nhs.net) The Health Centre will verify if sufficient evidence exists in the medical record for the problem listed in section 2. All information given will be treated as confidential. | | | | | |
| **Section 1 PERSONAL DETAILS OF STUDENT** | | | | | |
| Full Name: | |  | Student ID Number: | |  |
| Date of Birth: | |  | Year of Study: | |  |
| Course: | |  | **Category 1, 2 or 3** | |  |
| PINK or BLUE Practice | |  | This form will only  be completed if you have paid | | Please call the Health Centre to pay £20 prior to submitting |
| First day of sickness: | |  | Last day of sickness if known | |  |
| How long has illness lasted (tick appropriate box) | | 1 – 2 Weeks | 2 – 4 Weeks | | Longer/on-going |
| Seen by clinician at the time of illness (delete as appropriate) Yes / No  List dates if known: | | | | | |
| If you want to **Withdraw from Studies** – It would be in your best interest to have a consultation with a GP prior to submitting this form | | | | | |
| If you want to **Return to Studies** – You will need to have a consultation with a GP prior to submitting this form | | | | | |
| **Do you want to collect from the Health Centre? YES / NO**  **If NO please provide your Warwick Email Address:** | | | | | |
| **Section 2 TO BE COMPLETED BY STUDENT** | | | | | |
| **GIVE FULL DETAILS OF YOUR PROBLEM, LIST AND DATE ALL ACTIVITIES WHICH HAVE BEEN AFFECTED AND THE CATEGORY CERTIFICATE YOU ARE REQUESTING 1, 2 OR 3**  **(The form will not be completed by the Health Centre without this information)**  If the period of illness described on this note affected an examination or significant piece of assessment (i.e. contributing to your progress to the next year or to your degree classification), please list the examinations or assessments which you believe were affected and give all relevant dates:  I confirm that I the above named student is suffering from or has suffered from a significant illness which falls into one of the categories listed below and that it has had a significant impact on my studies  **Students Signature**  (electronic signature accepted) **Date**  I consent to the Clinician providing the information. It is my responsibility to pay any fees for the Medical Certificate and to ensure there is no undue delay on my part in this being sent to the University | | | | | |
| **CATEGORY 1**  Significant Illness{e.g. hospital admission, operations, glandular fever, severe pyelonephritis, infectious disease, illness lasting more than 7 days} | | | | | |
| **CATEGORY 2**  On-going Illness Diagnosis (already known to the University) | | | | | |
| **CATEGORY 3**  Any other illness / condition impairing performance in examinations or assessments counting towards a degree or progression | | | | | |
| **Section 3 TO BE COMPLETED BY THE HEALTH CENTRE** | | | | | |
| **FOR ALL CATEGORIES**  **Patient seen at time of illness YES / NO**  **There is sufficient evidence from the medical record to confirm illness /condition as described in section 2 above YES / NO** | | | | | |
| Date of Consultation with Clinician: | | | | | |
| Any other comments: | | | | | |
| GP Name: |  | | |  | |
| Signature: |  | | |
| Date: |  | | |

**Medical Certificates will be ready for collection within 3 working days**