

Faculty of Medicine, University of Jaffna
Disability Disclosure Form

Name		
Reg.No./Emp.No./		
Please let us know the nature of the disability (check all that apply)* Here disability refers to any impairment that has the potential to restrict your participation in academic, work-related or social activities at the Faculty.		
1	Mobility impairment	<input type="checkbox"/>
2	Visual impairment	<input type="checkbox"/>
3	Hearing impairment	<input type="checkbox"/>
4	Mental health condition	<input type="checkbox"/>
5	Learning difficulty (e.g. dyslexia, ADHD)	<input type="checkbox"/>
6	Any other health condition requiring support (specify)	<input type="checkbox"/>
I have enclosed medical documentation regarding my disability and evidence of having completed a rehabilitation programme.		<input type="checkbox"/>
I give my consent for the Faculty of Medicine, University of Jaffna, to share relevant information with persons authorised by the Faculty Board about my disability and/or any adjustments/accommodations that I may require. This includes disclosure of my disability to faculty, teaching and administrative staff and providers of financial assistance, if the latter is required.		<input type="checkbox"/>

Signature:-----

Date:-----

Please complete this form and return it along with appropriate documentation to the Office of the Dean, Faculty of Medicine, University of Jaffna, to be forwarded to the Committee on Disability Access and Inclusion for consideration.