Priority – medical statement

1. To apply for a Short-term Learning Opportunity, the student is encouraged to submit a statement from the treating licensed clinical professional or health care provider that confirms that the student has fewer opportunities due to a disability, chronic health condition or other medical issue(s). The professional/provider must be thoroughly familiar with the student's physical or psychological condition(s) and resulting functional limitations, restrictions or considerations.

2. This statement should not contain any medical information, other than the confirmation that this document provides.

3. All information and documents will be kept confidential and stored safely. Any confidential information will be shared only with relevant staff and in a discreet manner.

4. If you require special facilities and/or support during your studies that are not met with this top-up or the Erasmus+ grant in general, please visit the UvA's webpage on **Studying with a disability, dyslexia or chronic illness**. You may also want to make an appointment with one of the UvA student counsellors to discuss your situation, you can find more information and their contact details **here**.

Priority – medical statement

Student fills out the section below.

Student Name: _____

Student Number: _____

Faculty: _____

I have read and understood the information contained in this request for the Erasmus+ Inclusion top-up and agree to the following:

- I have filled in this form truthfully.
- I will upload a scan of this document to my application for the Erasmus+ grant on Canvas.

Student signature:

_____

Date: _____ Place: _____

Medical/health care provider fills out section below.

Name and title: _____

Address: _____

Phone: _____

Email: _____

I hereby confirm that the student named above, is suffering from a disability, chronic health condition or medical issue(s) that is/are in any way limiting to their (physical) opportunities in international mobilities, study or traineeship abroad.

Signature of medical/health care provider:

_____

Date: _____ Place: _____