



Please complete and return this form:
By Email: Secretary@ncgu.co.uk or
By Post: The Secretary, NCGU 14 Rydal Close, Penistone,
South Yorkshire, S36 8HN

MEDICAL CERTIFICATE FOR THE USE OF A GOLF BUGGY IN COMPETITION

This Medical Certificate constitutes a 'medical confirmation of disability' to be read in conjunction with the Northern Counties Golf Union Transportation Policy. By submitting this form you consent to Northern Counties Golf Union processing and storing the personal data contained herein for the purpose of administering competitions and processing your request to use a golf buggy.

This Medical Certificate is valid for the length of time that the Player's Medical Representative believes the impairment will have a substantial adverse effect on the ability to carry out day-to-day activities and play a round of golf. The Player may be asked to revalidate this Medical Certificate where their impairment is temporary or may be cured or substantially reduced.

Please note that any expense incurred for completing this form is the responsibility of the Player.

To be completed by the Player:

I, (Name)

of (Address)

request the use of a golf buggy during the Northern Counties Golf Union

event as a reasonable adjustment for a disability within the meaning of the Equality Act 2010.

I confirm that the information contained in this document is, to the best of my knowledge, a true and accurate reflection of my medical circumstances as of the date of this Medical Certificate.

Signed _____ Date

Phone No. _____

To be completed by the Player's Medical Representative

Please answer the following questions in order to give us your opinion as to whether the above named player ("The Player") requires transportation in the form of a golf buggy to play golf. Please note that we require all of the questions below to be answered in order to make a decision regarding the Player's request to use a golf buggy. Please circle or delete as appropriate:

1) Does the Player experience symptoms of, or suffer with, a physical or mental impairment?

Yes / No

2) Does the Player's impairment have a substantial adverse effect on their ability to walk long distances, carry golf clubs, or otherwise play a round of golf?

Yes / No

3) Has the Player experienced symptoms of, or suffered with the impairment for a period of over 12 months?

Yes / No

4) Is the Player's impairment permanent or temporary?

Permanent / Temporary

If the Impairment is permanent:

Could the impairment be cured or substantially reduced by some treatment or medical procedure?

If the impairment is temporary:

Provide your opinion on how long the impairment will continue to affect the Player substantially.

I, Dr (Name)

_____ of Address / practice stamp

certify that I have assessed the Player and confirm that the information and evidence provided in this document is, in my professional opinion, accurate."

Signed _____

Date _____ Phone No. _____