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Please refer to the Reasonable Adjustment Policy for guidelines and application process.

USE BLOCK LETTERS WHEN COMPLETING THIS FORM AND PLEASE KEEP A COPY

Personal details

Title Mr Ms Other Gender M F Unspecified

Family name First name(s)

Date of birth (dd/mm/yyyy) Student ID

Phone number Email

Address

City State Postcode

Program:

Reasonable Adjustment sought (can be completed with a College Disability Liaison Officer once the verification and impact statement below is complete):

Declaration:

I understand that the submission of an application for Reasonable Adjustment does not automatically mean it will be approved.

I understand that material provided by me to the College will be kept confidential and private. This information may be used to contact medical practitioners or other relevant parties to verify the authenticity of supporting documentation provided in my application.

Information in this application may be shared with relevant staff (e.g. teachers, University of Adelaide Disability Support) in order to meet requests for reasonable adjustment.

Personal information collected by, and in connection with, this document may constitute 'sensitive information' under applicable privacy legislation. Please indicate your consent regarding the handling of that information by the College (including Kaplan Higher Education Pty Ltd), The University of Adelaide and other relevant entities (including Kaplan's associated entities).

I confirm that I am 16 years of age or older, and explicitly consent to the collection, storage, use, transferring, disclosing and other handling of my personal information (including sensitive information) in connection with, and for the purposes of, receiving, assessing and verifying my application for reasonable adjustment and, if a reasonable adjustment is to be made, implementing that adjustment.

I am NOT located in the People's Republic of China OR

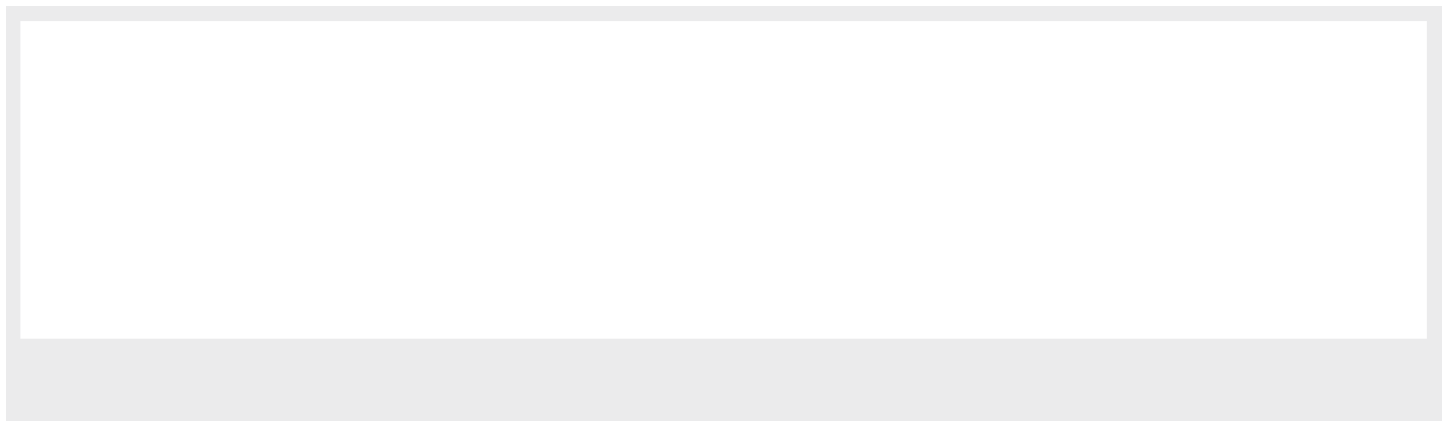
I AM located in the People's Republic of China and I consent to transferring and sharing my personal information (including sensitive information) outside the People's Republic of China (and I understand that Kaplan's 'Personal Information Protection Policy' (available at <https://www.kic.org.cn/privacy/>) applies to personal information about individuals located in the People's Republic of China).

Signature (Student): Date:

Please complete the Verification and Impact Statement over the page with your medical professional.

Please return your application to the relevant College staff:

- Prospective students: college@adelaide.edu.au
- Foundation Studies students: collegefsp@adelaide.edu.au
- Degree Transfer Bridging students: collegeedtp@adelaide.edu.au
- Pre-Master's Bridging students: collegepmp@adelaide.edu.au
- General Academic English students: please direct to contact above for the student's pathway program





Verification and Impact Statement

Examples of appropriate practitioners include: GPs (General Practitioners)
Psychologists
Audiologists

If you are unsure as to whether any other practitioners can complete this form, please contact the relevant College sta for your program. Please note the practitioner must be an independent person. That is, a person who is not a close relative (i.e. partner, spouse, child, sibling, parent, grandparent, uncle or aunt) or close associate (e.g. friend, extended family member, neighbour, or partner of children or colleague).

Authority Release

I hereby give authority for to
(Student Name) (Practitioner)

release information in this report to the University of Adelaide College sta working with my application. I also authorise the University of Adelaide sta to discuss this report and my condition with the practitioner below.

Signature: _____ Date: _____

Practitioner's Report

This information is required for the sole purpose of ensuring that this student's condition will not disadvantage or negatively impact on study. While you are under no obligation to complete this document, the student will not be able to obtain appropriate support without this information.

Practitioner: _____
Profession: _____
Phone: _____
Email: _____
Signature: _____ Date: _____

Practitioner's Stamp

Disability Information: To Be Completed by Medical Practitioner/Health Care Provider

Diagnosis: _____

Description of Condition: _____

Date Diagnosed _____

Disability Type Hearing Learning Medical Psychological Neurological Physical Visual

Disability Category Mild Moderate Profound Severe

Disability Status: Ongoing Stable Ongoing Fluctuating/Episodic Ongoing Degenerative

(Please tick only one.)

If the condition is temporary, provide the Temporary Stable Duration: _____

estimated duration.) Temporary Fluctuating Duration: _____

Date to be Reviewed _____



Impact on Study – please describe impact on student’s study

Impact of treatment (eg. sedation, absence etc. - please indicate only if treatment/medication is likely to impact on the student’s study)

Upon cognitive skills (eg. attention and concentration; planning and organisation; processing skills—auditory and visual; conceptual skills— sequencing and integration; memory; other)

Upon reading (eg. standard print; from blackboard/overhead projectors; speed; comprehension; other)

Upon writing (eg. ability; speed; spelling; punctuation; grammar; text organisation; other)

Upon other associated areas (eg. understanding spoken language; using spoken language; participating in groups; making presentations; regular attendance at lectures/practicals; collaborating with others; completing work independently; performing calculations; fine motor skills/manipulating objects; other)



Safety Plan

This document is to be completed by a medical practitioner or other appropriate health professional if a student has a medical or mental health condition which may require a safety plan. This information will be kept on the student's file at the College and shared with relevant College and University staff as reasonably necessary to ensure an informed crisis response if required.
