THE UNIVERSITY of ADELAIDE
COLLEGE

Application for

REASONABLE ADJUSTMENT

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: collegedtp@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

OFFICE USE ONLY

TO BE COMPLETED BY STUDENT SERVICES MANAGER

Date application received:

Date of decision:

☐ Approved ☐ Not approved Student advised of decision in writing ☐

Reason for decline:

Signature (Disability Liaison Officer):

Date:

Foundation Studies, Degree Transfer and Pre-Master's programs (The University of Adelaide) CRICOS 00123M | English language programs (Kaplan) CRICOS 03127E. Published February 2022.

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 staff 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 staff working with my application. I also authorise the University of Adelaide staff 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: (Please tick only one. If the condition is temporary, provide the estimated duration.)	☐ Ongoing Stable		☐ Ongoing Fluctuating/Episodic		☐ Ongoing Degenerative		
	☐ Temporary Stable		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)

Upon accessing the physical environment (eg. opening heavy doors; negotiating stairs; using a standard computer; using standard seating; standard acoustics; standard ventilation; retrieving books from library shelves; moving easily between venues on campus; other)

Does the student require specific equipment, furniture or adaptive software?

In view of the areas indicated above, please consider the impact of the student's disability/chronic medical condition in an examination or assignment situation (eg. extra time; rest break; permission to take in medication, food, drink or other support/requirements; use of equipment such as a computer, ergonomic furniture etc; separate venue; special consideration re incorrect grammar and spelling; other).

Other Comments:

Does this student require a medical or mental health safety plan? ☐ Yes - please fill out the safety plan below ☐ No

Thank you for your assistance in providing this documentation. This will greatly assist the College in assessing and negotiating appropriate academic adjustments for this student to enable equal participation in their education at The University of Adelaide College.

Student Name: Student Id:

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.

Warning Signs (ie. signs and symptoms, behaviour) that a medical or psychiatric crisis may be developing:

1.

2.

3.

4.

5.

Student's self-management to stay safe:

1.

2.

3.

4.

5.

Medical or Other Health Professionals contact details:

Professional's name: Contact number:

Professional's name: Contact number:

Local area health service crisis team: Contact number:

Other:

Medical or Health Professional Providing Safety Plan

Professional's name:

Signature: Date:

I ..... give permission to release this information as outlined above.
(Student Name)

Signature (Student): Date: