



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	<input type="checkbox"/> Mr	<input type="checkbox"/> Ms	<input type="checkbox"/> Other	Gender	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> 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.

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

Degree Transfer Standard and Pre-Master's 1 semester/ trimester students wishing to apply for reasonable adjustment should refer to the University of Adelaide adelaide.edu.au/policies

OFFICE USE ONLY	
TO BE COMPLETED BY STUDENT SERVICES MANAGER	
Date application received:	Date of decision:
<input type="checkbox"/> Approved	<input type="checkbox"/> Not approved
Student advised of decision in writing <input type="checkbox"/>	
Reason for decline:	
Signature (Disability Liaison Officer):	Date:

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.) Ongoing Stable Ongoing Fluctuating/Episodic Ongoing Degenerative

If the condition is temporary, provide the estimated duration. 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: _____