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**APPLICANT DETAILS**

**Name:**

**QTAC Application Number:**

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**ELIGIBILITY TO APPLY**

Complete this form if you have experienced personal injury, illness or have a diagnosed disability and your education provider could not fully compensate for your circumstances.

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**APPLICANT STATEMENT** (please tick the relevant box. You can select more than one option)

1. I have experienced:

- A disability
- A long-term or recurrent medical or psychological condition
- A serious short-term medical or psychological condition
- Learning difficulties

2. Name of my condition or disability: \_\_\_\_\_

I have obtained Approved Provisions from my state Education Authority for access arrangements and reasonable adjustments for assessment. Copy of letter of advice attached.

3. My condition affected my most recent studies because: **(please type directly onto the form or print clearly)**

Applicant to sign: \_\_\_\_\_

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**SUPPORTING DOCUMENTATION** (documents must be included with this form)

**You MUST provide** the following supporting documentation that substantiates the information you provided in your personal statement:

- Page 2 of this form completed by your school if you are a Year 12 student
- Page 3 of this form completed by your Primary Health Care Provider (generally your General Practitioner)

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**SCHOOL STATEMENT** (NOTE: This section is only required if you are completing Yr 12 or equivalent)

**(To be completed by a Guidance Officer or other appropriate school representative)**

**Please read the applicant statement and comment appropriately.**

1. Days absent as a result of this condition: Year 11: \_\_\_\_\_ Year 12: \_\_\_\_\_ Other: \_\_\_\_\_

2. Please describe the impact of this medical condition/disability on the applicant's academic performance. You may wish to include your statement as an attachment.

3. Indicate any adjustments made for this student:

No adjustments made

Additional time to complete tasks

Extensions for assignments

Exemption from assessment

Re-scheduling exams

Counselling/school support

Variable Progression Rate

Alternative arrangements for exams

Specialised equipment for disability

Reader/scribe for physical impairment

Variation in tasks for sensory/physically impaired

Modified curriculum

Learning Plan in place

Other \_\_\_\_\_

4. What was the extent of this adjustment?

Applied to all subjects

Other \_\_\_\_\_

5. Taking into account the adjustments made above, what was the severity of impact on the student's academic performance. Please consider whether this instance is less or more serious than other students applying under this category, and apply ratings accordingly (**please mark X on line below**).

**Severity of Impact on school performance after above allowances/provisions have been made**

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No impact	Limited	Minor	Moderate	Mod/severe	Severe	Severe/ profound	Very profound
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Documentation attached

Name of education provider: \_\_\_\_\_ Suburb/Town: \_\_\_\_\_

School representative: \_\_\_\_\_ Position: \_\_\_\_\_

School representative to sign: \_\_\_\_\_ Date completed: \_\_\_\_\_

Please have the **PATIENT STATEMENT** on page 3 of this document completed by your Primary Health Care Provider.

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## PATIENT STATEMENT

**(health care professional to complete – applicants must not write in this section)**

1. Medical condition/disability: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Describe the condition affecting the patient:

How long has the patient been affected by the medical condition/disability?

Less than 6 months

1–2 years

5–10 years

6–11 months

2–4 years

Life long

To your knowledge, what treatment has the patient received?

Name and class of medication (if relevant) \_\_\_\_\_

How long has the patient been receiving treatment? \_\_\_\_\_

How often has this treatment been? daily/weekly/monthly/irregularly/other \_\_\_\_\_

When did this treatment end? \_\_\_\_\_

2. Indicate the impact of the medical condition/disability on the patient's ability to study by ticking the appropriate box:

Extreme

Slight

Considerable

Not at all

Moderate

Please describe the nature of the impact (eg Jessie would have had trouble concentrating.)

3. Details of registered health professional

(medical practitioner, psychiatrist, psychologist or specialist **not related to the applicant**)

Name of health care professional: \_\_\_\_\_

Position/occupation: \_\_\_\_\_ Reg/Provider No: \_\_\_\_\_

Name of organisation (eg Mater Hospital): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Attach this to documentation and return to QTAC**

**Upload** your documentation to your online application at <https://applications.qtac.edu.au>