**Access*Ability* Services Registration Form**

**Part 1) Consent to Release Information Form – to be completed by student**

This form gives written authority to staff from Swinburne University’s Access*Ability* Services to OBTAIN AND RELEASE information relevant to your study requirements and support needs. Please read the information carefully and talk to the Access*Ability* Adviser if you have any concerns.

Any personal information provided by you (or on your behalf) to the Access*Ability* Services will remain confidential and will not be disclosed without your written or verbal consent. The only exception is where there are over-riding legal requirements (e.g. court orders). The Commonwealth Department of Education will require your student number for validity of your enrolment if you require direct support. All information kept by Access*Ability* Services is stored on secure intranet servers and is only accessible by the staff working within Access*Ability* Services. Information that is not classified as personal (e.g. exam arrangements) may be shared with relevant parties at the Access*Ability* Adviser’s discretion.

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| --- | --- | --- | --- | --- | --- | --- |
| **Student Details Please complete all details** | | | | | | |
| **Full Name** |  | | | | | |
| **Student ID Number** | # | | Domestic Student | | | International Student |
| **Contact Phone Number** | h. m. | | | | | |
| **Emergency Contact** | Name: Relationship: Phone: | | | | | |
| **Course** |  | | | | | |
| **Campus** | Hawthorn  Off-Campus | Croydon  Wantirna | | Swinburne Online  OUA | |  |
| **Division** | Higher Ed | Pathways & Vocational Education | | | Short Course | |

I give permission for staff within Access*Ability* Services to discuss issues relating to my disability and support needs to the following individuals or members of the organisations listed below:

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| --- | --- | --- | --- |
| **Name** | **Information (eg. name, organisation, relationship etc)** | | **Contact Details** |
| Relevant Swinburne Staff |  |  |  |
| Student Development and Counselling |  |  |  |
| Swinburne Health Service |  |  |  |
| Swinburne Careers and Employment Service |  |  |  |
| Swinburne Professional Placements |  |  |  |
| SSAA (Swinburne Student Amenities Assoc.) |  |  |  |
| Education Access Worker (support staff) |  |  |  |
| Case / Employment Manager |  |  |  |
| Parents / Carers |  |  |  |
| Doctor |  |  |  |
| Psychologist/ Psychiatrist |  |  |  |
| Other |  |  |  |

I understand that the information communicated with the above individuals or organisations will be relevant to my study and/or support needs.. Should I wish to withdraw my consent at any time, I will contact Access*Ability* Services and inform them in writing.

Swinburne’s privacy statement can be viewed at: <http://www.swinburne.edu.au/privacy/>

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| **Signature (student)** |  |  | **Date** |  |  |  |

**Part 2) Disability/Medical/ Carer Documentation Form – to be completed by a treating Health Practitioner**

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| **Swinburne University of Technology Disability / Medical / Carer Documentation Form** |
| Access*Ability* Services requires a student to provide proof of a disability, medical condition or carer status from a relevant treating health professional before they are eligible to receive support.  This form should be completed by a qualified health professional (please see “Eligibility Guidelines” for more information).  The information provided will remain confidential and be used by Access*Ability* Services at Swinburne University of Technology to negotiate appropriate reasonable adjustments and Equitable Assessment Arrangements to be included in the student’s Education Access Plan. |

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| **Student Details** | | | |
| **Full Name** |  | | |
| **Student ID Number** | # |  |  |

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| **Qualified Health Professional – please write legibly** | | | | | | | | |  | | | | | | | |
| **Full Name** | |  | | | | | | | | | | | | | | |
| **Occupation** | |  | |  | | **Contact no.** | |  | | | | | | |  |  |
| **This report must be accompanied by the qualified health professional’s stamp or business card**: | | | | | | | | | | | | | | | | |
| **Disability Information (To be completed by a relevant health professional)** | | | | | | | | | | |  | | | | | |
| **Disability Type (please tick)** | | | Hearing | | Vision | | | | | Physical | | | | | | |
| Mental Health | | Learning | | | | | Neurological | | | | | | |
| Medical | | Intellectual | | | | | Other: | | | | | | |
| **Diagnosis** | | |  | |  | | | | | | | | |  | | |
| **Duration** | | | Ongoing | | Episodic | | | | | | | Temporary –  from \_\_/\_\_/\_\_ to \_\_/\_\_/\_\_ | | | | |
| **How does the disability/medical condition/carer responsibility affect the student’s ability to study and participate in their education?**  **(e.g. fatigue, loss of concentration, pain, time constraints etc.)** | | | | | | | | | | | | | | | | |
| **What recommendations do you make for reasonable adjustments / Equitable Assessment Arrangements or support required to enable equal participation by this student?**  **(e.g. Extra time and /or use of computer for examinations, provision of note taking, adaptive equipment etc.)** | | | | | | | | | | | | | | | | |
| **Signature (health professional)** |  | | |  | | | **Date** | | | | | |  | |  |  |

**Please return completed form together with any other relevant information to:**

**AccessAbility Services**

Swinburne University of Technology,

H22, PO Box 218 Hawthorn VIC 3122

Phone: +61 3 9214 5234

Email: [accessability@swin.edu.au](mailto:accessability@swin.edu.au)

Web: <http://www.swinburne.edu.au/accessability/>

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| --- | --- | --- | --- | --- | --- |
| **OFFICE USE ONLY** | | | | | |
| Date Received: |  | Received by: |  | Scanned: |  |

**\* NOTE: Please make sure you keep a copy of this form for your personal records.**