

Equitable Learning Services

Registration and supporting documentation form

Use this form to provide Equitable Learning Services information about the impact of your disability, long-term illness and/or mental health condition on your studies. You will need to fill out **section A** and ask your health practitioner/provider to fill out **section B**.

Confidentiality and privacy statement

This form gives Equitable Learning Services permission to store and communicate necessary information about you. Before signing the form, please read the information below. If you have any questions, please contact us via RMIT Connect on 9925 5000. Submit this form at your Equitable Learning Services consultation.

Equitable Learning Services stores and communicates student information according to the requirements of the Information Privacy Act 2000 and, where health information is concerned, the Health Records Act 2001. We will use this information to:

- register you with Equitable Learning Services
- determine and organise services for you
- provide the Commonwealth and state governments statistical data for funding purposes (only RMIT student numbers are provided)

We will protect the confidentiality of information as required by the legislation. It may be necessary to discuss information that you have provided with RMIT staff outside Equitable Learning Services or with an agency external to the University e.g. Open Universities Australia (OUA). The information disclosed will be kept to a minimum and those receiving it will be aware that it is given in confidence.

For more information, please read RMIT's information privacy policy at <http://www.rmit.edu.au/privacy>

Section A: Student details

First Name: _____ Family Name: _____

Student number: _____ Telephone: _____

By signing this form, I acknowledge that I have read and agree with the privacy and confidentiality statement and I authorise Equitable Learning Services to seek information from my health practitioner or provider.

Student signature: _____ Date: _____

Do you identify as an Australian Aboriginal and/or Torres Strait Islander?

Yes

No

I do not wish to disclose

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Section B: to be completed by practitioner or health care provider

Provider stamp/number

Practitioner's name: _____

Address: _____

Name (diagnosis) of disability, long-term illness and/or mental health condition:

Indicate condition:

- Hearing Vision Physical Neurological
 Medical Mental health Other: _____

Indicate duration of condition:

- 6 months 1 year 2 years Ongoing

Indicate impact of condition:

- Fluctuating Constant Improving Degenerating

How does the disability, long-term illness and/or mental health condition impact on the student's study? (for example, inability to sit for long periods, fatigue, loss of concentration) Attach further information if required.

Other comments or suggestions that may assist with determining support (for example, rest breaks or extra writing time for exams).

Practitioner's signature: _____

Date: _____