#  Equitable Learning Services


#  Registration/Confidentiality form

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 ask contact us via RMIT Connect on 9925 5000. Submit this form and the supporting documentation form at your Equitable Learning Services consultation.

##  CONFIDENTIALITY AND PRIVACY STATEMENT

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](http://www.rmit.edu.au/privacy)

Please enter your details in the form below.

Given name:

Family name:

RMIT student number:

Mobile number:

Please type “yes” next to your disability, long-term illness and/or mental health condition in the table below.

|  |  |
| --- | --- |
| Hearing |  |
| Neurological |  |
| Vision |  |
| Physical |  |
| Mental health |  |
| Medical |  |
| Other |  |

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

[ ]  Yes

[ ]  No

I have read and agree with the privacy and confidentiality statement and I authorise RMIT to seek information from my health practitioner or provider.

Signature:

Date: