



# Reasonable Adjustment/Special Needs Form

## **PART A**

To be completed by the **STUDENT** applying for Reasonable Adjustment / Special Needs

Student Details:							
Student Number	ACE _____	Date of Birth	___/___/_____				
Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other _____			Gender (Please tick)		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Given Names			Surname				
Address							
State		Country		Postcode		Email	
Phone Number (H)			Phone Number (W)			Mobile:	
Emergency Details:							
Name				Relationship			
Phone Number (H)			Phone Number (W)			Mobile	
Course Details: Please tick your elected course(s)							
<input type="checkbox"/> SIT30813 Certificate III in Commercial Cookery ( <b>In Transition</b> )				<input type="checkbox"/> BSB40215 Certificate IV in Business			
<input type="checkbox"/> SIT40413 Certificate IV in Commercial Cookery ( <b>In Transition</b> )				<input type="checkbox"/> BSB50215 Diploma of Business			
<input type="checkbox"/> SIT50313 Diploma of Hospitality ( <b>In Transition</b> )				<input type="checkbox"/> BSB60215 Advanced Diploma of Business			
<input type="checkbox"/> AUR30612 Certificate III in Light Vehicle Mechanical Technology ( <b>In Transition</b> )							
Reasonable Adjustment: Please Indicate below the special arrangement(s) requested:							
<input type="checkbox"/> Amanuensis/Scribe		<input type="checkbox"/> Medicine – Permission to take			<input type="checkbox"/> Computer		
<input type="checkbox"/> Equipment – Specialised/personal		<input type="checkbox"/> Additional Writing Time			<input type="checkbox"/> Wheelchair Access		
<input type="checkbox"/> Ergonomic Furniture		<input type="checkbox"/> Movement – Permission to move about			<input type="checkbox"/> Speech Synthesiser		
<input type="checkbox"/> Interpreter (signing or oral)		<input type="checkbox"/> Other (please specify): _____					
<input type="checkbox"/> Separate/private venue							
Special Circumstances: I wish to apply for Special Consideration based on the following circumstances (if the request is on medical grounds your doctor must complete Part B or attach medical certificate). In ALL other cases please provide a statutory declaration with any supporting information.							



## Reasonable Adjustment/Special Needs Form

I have attached one of the following:

### Application on medical grounds

- Part B of this form completed by my doctor, or a Medical Certificate to support my application

### Application on other grounds

- Statutory Declaration plus any supporting documentation

**Applicants submitted without one of the above documentation will not be processed.**

### Student Declaration:

- I give consent for the Student Support Officer (SSO) to discuss my training needs and restrictions with relevant staff at ACE.
- I hereby confirm that the information given by me is true and correct to the best of my knowledge.

Student Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_

## PART B

To be completed by a **Legally Qualified Medical Practitioner** (e.g. General Practitioner, Psychiatrist, Specialist)

### **Student Details:**

Student Number	ACE _____	Date of Birth	___/___/_____
Surname		Given Name	

### **Medical Practitioner Details:**

Doctor's Name		Surgery Address	
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I, \_\_\_\_\_, a legally qualified medical practitioner

Examined (Patient's name Block Letters) \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_\_\_

### **The Patient:**

is suffering from \_\_\_\_\_  
*(diagnosis to be provided with patient consent where possible)*

**OR**

- is suffering from a medical condition of a confidential nature.

**AND**

The illness is considered:  chronic OR  acute *(please tick)*

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## Reasonable Adjustment/Special Needs Form

**Please complete ALL information in section below:**

In my opinion, the following medical restrictions may impede on the student's ability to undertake full-time study (20 hours per week) in a classroom setting:

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In my opinion these restrictions are likely to hinder the student:

Within the period of \_\_\_\_\_ to \_\_\_\_\_ (dates) **OR**  permanently (please tick if applicable)

Please provide any recommendations regarding reasonable adjustments/additional support that the student requires in order to undertake the inherent requirements of their studies: \_\_\_\_\_

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Signature of Medical Practitioner \_\_\_\_\_ Stamp:

Date \_\_\_/\_\_\_/\_\_\_\_\_

### **PART C**

To be completed by the **Student Support Officer (SSO)** and signed by the **Student** (to indicate their endorsement of the reasonable adjustment/support offered by ACE)

#### **SSO Details:**

Given Name		Surname	
Position			
Date	___/___/_____		

#### **Student Details:**

Student Number	ACE _____	Name	
Nature of Medical Condition / Special Needs			
Medical Restrictions affecting students capacity to work			
Course Code		Course Title	

