

## APPLICANT DETAILS

**Name:**

**QTAC Application Number:**

## 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.

## APPLICANT STATEMENT

1. I have experienced:

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

- ☐ A long-term or recurrent medical or psychiatric condition or disability; and/or
- ☐ A serious, short-term medical or psychiatric condition; and/or
- ☐ A learning, sensory, physical, psychological, or other disability or disorder

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

3. This affected my most recent studies because:

(please type directly onto the form or print clearly)

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

## 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)

You may also wish to attach your official academic results showing how your circumstances have affected your educational performance, if appropriate.

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## SCHOOL STATEMENT

**(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:

- |  |   |
|--|---|
| <input type="checkbox"/> No adjustments made               | <input type="checkbox"/> Specialised equipment for disability               |
| <input type="checkbox"/> Additional time to complete tasks | <input type="checkbox"/> Reader/scribe for physical impairment              |
| <input type="checkbox"/> Extensions for assignments        | <input type="checkbox"/> Variation in tasks for sensory/physically impaired |
| <input type="checkbox"/> Exemption from assessment         | <input type="checkbox"/> Modified curriculum                                |
| <input type="checkbox"/> Re-scheduling exams               | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Counselling/school support        |   |

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.



**No impact**

**Profound & Chronic Impact**

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☐ Documentation attached

Name of education provider: \_\_\_\_\_

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

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

Please pass this document to your Primary Health Care Provider for completion.  
PATIENT STATEMENT on page 3 of this application form.

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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

☐ 6–11 months

☐ More than 2 years

To your knowledge, what treatment has the patient received?

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. Impact on ability to study

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 John 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>.