Address: 41 Boundary Road, North Melbourne, VIC. 3051
Email: info@scei-he.edu.au I Phone: +61 3 9602 4110
Web: www.scei-he.edu.au

HEFOR05 Equitable Learning Registration Form

Registration and supporting documentation form

Use this form to provide Southern Cross Education Institute – Higher Education 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 Southern Cross Education Institute – Higher Education (SCEI-HE) 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 SCEI-HE Student Welfare on (03) 96 024 110. Submit this form at your Student Welfare consultation.

SCEI-HE 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 Student Welfare as a recipient of support services and/or reasonable academic adjustment
- determine and organise support services for you
- make a case for procurement of special access and study support hardware/software for you

We will protect the confidentiality of information as required by the legislation. It may be necessary to discuss information that you have provided with SCEI-HE staff or with an agency external to the SCEI-HE in order to procure support services. 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 SCEI-HE's **HEPP34 Privacy Policy** at: http://scei-he.edu.au/admission/privacy-policy/

Section A: Student details

First Name: _____ Family Name: _____

Student number: _____ Telephone: _____

Student email: _____

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

Student signature: _____Date: _____

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

Practitioner's name: _____

Address: _____

_____

Provider stamp/number

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: _____

HEFOR05
Version: 1.2
Review Date: February 2024

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Additional Notes On Diagnosis

Please use this space to elaborate on student's disability, long-term illness and/or mental health condition and its impact on student study.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

This Section is for Office Use Only

Receiving Application

This section is to be completed by the **SCEI-HE staff who is receiving** the form from the student.	☐ All Required Sections Completed ☐ Health Practitioner Details Provided ☐ Student Signature ☐ Supporting Documents Provided Staff Name _____ Staff Signature _____ Date _____ ***Please forward this to the Campus Manager and Dean for evaluation.***