

Study Adjustments Request Form

Student Authorisation for Provision of Information (to be completed by the student)

- I hereby authorise the medical practitioner or health care provider to provide the information below and in any attachments.
- I hereby authorise the Student Support Officer to contact the nominated medical practitioner /health care provider to discuss or clarify these supports if required.

Full Name: _____

Student ID: _____

Email: _____

Contact Number: _____

Course of Study: _____

Address: _____

Signature: _____

Date: _____

Practitioner Details (to be completed by a Health Practitioner)

Practitioner: _____

Profession (eg. GP, Psychologist): _____

Email: _____

Contact Number: _____

Signature: _____

Date: _____

Provider Stamp Practitioner/Health Care:

(This document must be accompanied by the
qualified health professional's stamp)

Stamp here

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Name of disabilities or medical conditions:

Indicate which category the disabilities/injuries/conditions best fits into:

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Neurological | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Mobility/Physical | <input type="checkbox"/> Learning | <input type="checkbox"/> Other |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Medical | _____ |

Please indicate whether disabilities/injuries/conditions are:

- | | | |
|-------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
|-------------------------------|-----------------------------------|---------------------------------|

Are these disabilities/injuries/conditions:

- | | | |
|------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Permanent | <input type="checkbox"/> Long-term* | <input type="checkbox"/> Temporary* |
|------------------------------------|-------------------------------------|-------------------------------------|

*Please provide details and expected date to be resolved:

Please list the potential functional impacts of the disabilities/injuries/conditions as they might apply to this student in relation to their study.

Please provide any specific suggestions for reasonable adjustments, in relation to the functional impacts listed above, that may assist this student to participate effectively in a learning environment?

Please note that where reasonable adjustments need to be made, the Student Support Officer will inform the relevant GLI staff of the adjustments that need to be implemented, not the disability.

All information provided is kept confidential in accordance with the Global Leadership Institute (GLI) [Information and Record Management Policy](#). For more information, please contact the Student Support Officer: studentsupport@gli.edu.au