Documents required

The University of Western Sydney Disability Service requires that all students seeking adjustments to their academic studies must provide relevant supporting documentation from a medical practitioner, psychologist or other accredited health or educational specialist at the time of registering with the Disability Service.

The documentation must be comprehensive and not older than two years at the time of registration. Medical certificates are not acceptable.

If documentation is provided by your treating specialist, it must be on official letterhead and must include:

- a clear statement of your condition, including diagnosis
- an estimation of the impact of the condition, including the effects of medication on your ability to meet the demands of academic studies at university
- an indication of whether your disability is temporary, permanent, fluctuating, episodic or progressive
- details of any restriction that prevents you from participating in any aspect of the learning program
- suggested recommendations as to how to address the impact of your condition will be considered

Alternatively, you can use the UWS Disability Service Medical Documentation form, which is available from the Disability Service website at www.uws.edu.au/disabilityservice.

If you are unsure who is the most appropriate professional to provide this information, please contact the Disability Service on (02) 9852 5199 or email disability@uws.edu.au.
Disability, Health Condition and/or Educational Professional Report

To access disability support services and reasonable adjustments from the University of Western Sydney (UWS), students are required to provide appropriate medical or educational documentation from an accredited health or educational professional.

An accredited health/educational professional should complete this form and supply current legible information together with recommendations for adjustments. The information provided will remain confidential and will be used by the Disability Advisor, Disability Service, to identify and implement reasonable adjustments in relation to academic studies for the student.

Consent to release/exchange information

I, ____________________________ (student’s name) hereby give authority for the UWS Disability Advisors to contact my health or educational professional, regarding documentation and the nature of my disability or health condition, and also for my health/educational professional to contact UWS Disability Service regarding documentation and the nature of my disability or medical condition.

Student details

Full name: ____________________________ Student ID number: ________________
Contact telephone number: ____________________________ Mobile: ____________________________
Course name: __________________________________________

Qualified health/educational professional

Full name: ____________________________ Provider number: ________________
Position: ____________________________ Date of report: ____________________________

This report must be accompanied by the accredited health/educational professional provider stamp or business card including registration number and contact details.
<table>
<thead>
<tr>
<th>Classification (please tick all that apply)</th>
<th>Expected duration (please tick most appropriate box)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Hearing impairment</td>
<td>□ Permanent</td>
</tr>
<tr>
<td>□ Vision impairment</td>
<td>□ Temporary</td>
</tr>
<tr>
<td>□ Mental health condition</td>
<td>□ Fluctuating</td>
</tr>
<tr>
<td>□ Physical disability</td>
<td>□ Episodic</td>
</tr>
<tr>
<td>□ AD/HD or ADD</td>
<td>□ Progressive</td>
</tr>
<tr>
<td>□ Acquired brain injury</td>
<td></td>
</tr>
<tr>
<td>□ Chronic health condition</td>
<td></td>
</tr>
<tr>
<td>□ Other (please provide details below)</td>
<td></td>
</tr>
</tbody>
</table>

Diagnosis:

Review date (if applicable):

Impact of disability, health condition or educational condition on study (consider reading, writing, typing, cognitive functioning, memory, concentration, communication, sitting tolerance, energy levels, mobility).

Effect of medication or current treatment (consider concentration, memory, stamina, attendance) on the student in the educational environment.
Does the student’s condition impact on the student being able to participate in the following? (Please tick all that apply)

- [ ] Field trips
- [ ] Practicum or work placements (consider transport/work patterns/tasks)
- [ ] Attending scheduled classes
- [ ] Taking own lecture notes
- [ ] Tutorial presentations
- [ ] Group work

Is the student able to participate in clinical/placement practicum?  
Yes [ ]  No [ ]

Specify if there are any restrictions on the student attending practicum/placement in the work environment (consider lifting, standing, hours of work, tasks prohibited):

<table>
<thead>
<tr>
<th>Specify if there are any restrictions on the student attending practicum/placement in the work environment (consider lifting, standing, hours of work, tasks prohibited):</th>
</tr>
</thead>
</table>

Are there any strategies that you would recommend to assist the Disability Advisor to identify appropriate and reasonable adjustments at university?

<table>
<thead>
<tr>
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</tr>
</thead>
</table>

Could the student’s condition as described above result in a medical emergency requiring assistance?  
Yes [ ] (Please complete the attached Emergency Response Plan)  No [ ]

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**Health/educational professional declaration and signature**

Health/educational professional Signature:  

Date:  

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CONFIDENTIAL – Emergency Response Plan

The following document is only required to be completed if it is likely the student may, due to their disability/health condition, require emergency medical treatment and will need to be transported to hospital. The information in the Emergency Response Plan will be provided by the Campus Safety and Security Duty Officer to the Ambulance Officer while on route to the university. The information contained in the Emergency Response Plan (ERP) is confidential.

The University of Western Sydney is committed to ensuring students with a disability are provided with appropriate accommodation to enable them to compete academically with their peers. The Disability Discrimination Act (1992) underpins the work undertaken in the Disability Service. The purpose of this information is to allow Campus Safety and Security to respond to a student's medical emergency in the most appropriate way to ensure the health and safety of the student. This information will be kept confidential and stored by both the Disability Service and Campus Safety and Security and will only be used if the student needs to be transported to hospital for emergency medical treatment.

Student/patient details

Full name: __________________________ Student ID number: ____________________

Date of birth: ________________________

Name of medical/chronic health condition:

Possible symptoms present if student is unwell and in need of assistance:

Assistance first aid trained staff should give in case of emergency:
Known allergies:

Name of professional/service who should be contacted in case of emergency:

Name and contact number of next of kin to be contacted in case of emergency:

Medical specialist signature - to be completed by treating medical/health specialist completing this form

Full name: ____________________________ Profession: ____________________________
Address: ____________________________
Contact telephone: __________________ Mobile: __________________
Medical practitioner’s signature: __________________
Date: ______________

Declaration and signature - to be completed by student

I, ____________________________, (student’s name) hereby give permission for the above information to be provided to the Disability Advisor, Disability Service, and the Director, UWS Campus Safety and Security. If I require emergency medical treatment, I give permission for the information in the Emergency Response Plan to be released to emergency medical services.
Permission is also given to advise my contact person of my medical emergency.

Student’s signature: ____________________________
Date: ______________