University of Southern Queensland

Health Practitioner Report

To register for disability support

(To be completed by the Practitioner / Health Care Provider)

If you have any questions regarding what content to include in this form, please see our Documentation Requirements on the UniSQ website.

Patient / Student Name: _____

Patient / Student DOB: _____

Diagnosis and description of the disability, injury, mental health, or medical condition/s:

_____

Indicate which category the disability/condition best fits into:

☐ Hearing ☐ Mobility/Physical ☐ Vision ☐ Mental Health
☐ Neurological ☐ Learning ☐ Medical ☐ Other _____

Please indicate whether this condition is:

☐ Permanent ☐ Long Term ☐ Temporary

NB: If not permanent, please indicate the date the condition is expected to be resolved or reviewed:

_____

This condition is:

☐ Stable ☐ Improving ☐ Degenerative ☐ Fluctuating

In my opinion this disability/condition will affect the following: (Please tick)

	In a minor way	Moderately	Severely
In-person examinations	☐	☐	☐
Online examinations	☐	☐	☐
Attending lectures	☐	☐	☐
Assignment completion	☐	☐	☐
Practical assessments	☐	☐	☐
Private study	☐	☐	☐

How does the functional impact of this student's condition impact on their ability to undertake study activities?

_____

Are there specific recommendations for reasonable adjustments that you believe may assist this student to enable equal participation in their university studies? E.g. Ergonomic seating, additional time, enlarged printing etc.

Notes / Other comments:

Please note: Reasonable adjustments will be assessed by the Accessibility Support team. A medical practitioner recommendation does not guarantee that an adjustment will be given, only that it will be considered. Reasonable Adjustments are required to maintain the inherent academic requirements of the course and to be in accordance with the Disability Standards for Education 2005.

Practitioner / Health Care Provider:

Name:

Title:

Practitioner/Health Care Provider Qualifications / Title (e.g.GP, Psychiatrist, Psychologist)

Address:

Phone:

Email:

Health Practitioner Signature:

Date:

Provider Stamp:

Students should email a copy of this completed form to disabilitysupport@usq.edu.au and retain the original for their records. The original must be provided upon request.

UniSQ is collecting the personal information on this form for the purpose of providing the services and assistance that you have requested. For a full understanding of our privacy information and management of your personal information, please access our Privacy Statement located at Reception or at www.usq.edu.au/student-support.