ZENITH INNOVATION INSTITUTE
UNPARALLELED EXCELLENCE

Student Reasonable Adjustment Form

Instructions

Complete this form if you wish to apply for reasonable adjustment to assist with your studies and submit it to Student Services:

- In person on the ground floor of the Zenith Innovation Institute campus at Level 7, 451 Pitt Street, Sydney, NSW 2000
- By email to: admin@zenithedu.com.au

STATEMENT OF PRIVACY, RECORDS AND CONFIDENTIALITY

By submitting this form, you confirm that the information provided is true and you understand that a person who intentionally provides false information will be subject to penalties under the Student Misconduct Policy and Procedure.

Zenith Innovation Institute would like to collect your personal information, including any sensitive information you provide in this form, (such as information about your health) for the purposes of assessing and investigating your reasonable adjustments application.

Zenith Innovation Institute values the privacy of every individual's personal information and is committed to the protection of that information from unauthorised use and disclosure, except where permitted by law.

If you have any questions about how Zenith Innovation Institute collects and handles your personal information, contact Student Services.

I acknowledge that I have read the declaration and privacy statements and give my consent to the personal information, including sensitive information, provided in this form to be used by the Institute in relation to my application for reasonable adjustments.

I provide the Institute consent to contact my medical practitioner and/or other person or organisation named in this documentation or supporting documentation to confirm or clarify information I have provided and to provide additional information relevant to my request for reasonable adjustments.

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Student Details

Full Name:	
Student ID:	
Address:	
Email:	
Contact Phone Number:	
Signature and Date:	

Health Provider Details

You may request your health professional to assist you to complete this form or on your behalf.

Health Professional Details	
Full Name:	
Profession:	
Address:	
Contact Phone Number:	
Email:	
Provider Number:	
Signature and Date:	

Disability Information

If applicable, you may wish to provide information regarding your diagnosis or disability status.

Diagnosis:		
Date Diagnosed:		
Condition or Disability Type(s):	☐ Physical ☐ Vision ☐ Hearing	☐ Learning ☐ Medical ☐ Psychological ☐ Neurological
Severity of Condition:	☐ Mild ☐ Moderate	☐ Severe ☐ Profound
Disability Status:	☐ Ongoing Stable	☐ Ongoing Fluctuating

	☐ Temporary Stable	☐ Temporary Fluctuating
Medication on Treatment Plan:		

Reason(s) for Reasonable Adjustment

You may wish to provide further information on your circumstances or condition to better inform reasonable adjustments.

Please tick the boxes for the areas in which you are affected:			
☐ Concentration ☐ Attention ☐ Focus ☐ Mental Fatigue ☐ Information Processing ☐ Distraction ☐ Memory ☐ Organisation ☐ Planning ☐ Prioritisation	☐ Task Switching ☐ Motivation ☐ Engagement ☐ Social Withdrawal ☐ Psychosis ☐ Stress Tolerance ☐ Decision Making Skills ☐ Variable Moods	☐ Agitation ☐ Procrastination ☐ Disrupted Thought Processes ☐ Avoidance ☐ Reduced Mobility ☐ Pain ☐ Discomfort ☐ Physical Fatigue ☐ Disruptive Symptoms	☐ Frequent Illnesses ☐ Reduced Communication ☐ Disrupted Sleep ☐ Hearing ☐ Sight ☐ Other (please specify)

Please explain the nature of your condition and the likely impact on academic performance and engagement:

If applicable, please explain the impacts of any medications you take or treatments you undergo in relation to your studies:

Recommendations

Based on the impacts previously mentioned, please outline any specific recommendations about the type of support required:

Safety Plan

Is a medical or mental safety plan required? ☐ Yes ☐ No

If 'Yes', please fill out the Safety Plan on the next page or include a copy on an existing plan.

The Safety Plan will be kept on file by Student Support so that we have this information available in the case of an incident where a student is in crisis. The Safety Plan will also be given to personnel who will assist you in the case of a crisis.

Student Details:			
Full Name:		Student ID:	
Warning Signs of Health Crisis:			
Student's Self-Management or Preventative Measures:			
Emergency Contacts (Medical and Personal)			
Professional Contact	**Personal Contact**		
Name: Relationship: Phone:	Name: Relationship: Phone:		
Name: Relationship: Phone:	Name: Relationship: Phone:		