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**AccessAbility Hub**

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# Health Practitioner Statement for Carers

## Instructions

This statement can only be completed and signed by a treating health practitioner who can verify that you have ongoing caring responsibilities for an adult or child who is Neurodiverse or lives with a mental health condition, ongoing or terminal medical condition, disability or who is frail and aged.

The practitioner should be registered with the Australian Health Practitioner Regulation Agency (AHPRA) or equivalent professional association.

Information provided will be used by an AccessAbility Adviser, in consultation with the student, to recommend reasonable adjustments to support the student in their studies at La Trobe University.

All information is collected in accordance with [Privacy Laws and Principles](https://www.latrobe.edu.au/privacy/laws-principles). Refer to La Trobe’s [Privacy Collection Notice](https://www.latrobe.edu.au/privacy/student-information/privacy-collection-notice) for more details.

***Student Authority for the provision of information (to be completed by the student)***

*Student Name: Student ID Number:*

*I hereby authorise my health practitioner to release relevant health information to the AccessAbility Hub, La Trobe University. I understand that my health practitioner may be contacted to discuss or verify any of the information contained in this form.*

*Student signature: Date:*

**I confirm that the above-named student is providing care to the following person/s in accordance with the Carer Recognition Act, 2010:**

*(Please use space provide below/attach additional documents if required)*

**I confirm that the person/s being cared for have neurodiversity support needs, or they live with or have a mental health condition, ongoing or terminal medical condition, disability or are frail and aged. The condition or disability is:**

[ ]  Short Term: until following date:

[ ]  Temporary: [x]  until mid-year [x]  for the academic year

[ ]  Ongoing: for the duration of studies

and is: [ ]  Fluctuating [ ]  Constant

**Please advise how the caring responsibilities are likely to impact on the student’s ability to study and participate in their university education, including attendance, deadlines, examinations and placement:**

*(Please use space provide below/attach additional documents if required)*

## Health Practitioner Declaration

By completing and signing this form you confirm that:

* I am the treating Health Practitioner for the above-named student or the person who is receiving care
* I am qualified to verify the circumstances for which the student is requesting reasonable adjustments
* I agree that I can be contacted to provide additional information or authenticate this document.

Name of Practitioner: Profession:

Phone number: Registration/Provider No:

Signature: Date: