QTAC CHOOSE THE FUTURE

Educational Access Scheme (EAS) Form
Personal Illness or Disability

APPLICANT DETAILS

Name:

QTAC Application Number:

ELIGIBILITY TO APPLY

Complete this form if you have experienced personal injury, illness or have a diagnosed disability and your education provider could not fully compensate for your circumstances.

APPLICANT STATEMENT

1. I have experienced:
   (please tick the relevant box. You can select more than one option)

☐ A long-term or recurrent medical or psychiatric condition or disability; and/or
☐ A serious, short-term medical or psychiatric condition; and/or
☐ A learning, sensory, physical, psychological, or other disability or disorder

2. Name of my condition or disability: _____

3. This affected my most recent studies because:
   (please type directly onto the form or print clearly)

Applicant to sign: _____

SUPPORTING DOCUMENTATION **(documents must be included with this form)**

You MUST provide the following supporting documentation that substantiates the information you provided in your personal statement:

- Page 2 of this form completed by your school if you are a Year 12 student
- Page 3 of this form completed by your Primary Health Care Provider (generally your General Practitioner)

You may also wish to attach your official academic results showing how your circumstances have affected your educational performance, if appropriate.

APPLICANT DETAILS

Name:

QTAC Application Number:

SCHOOL STATEMENT

(To be completed by a Guidance Officer or other appropriate school representative)
Please read the applicant statement and comment appropriately.

1. Days absent as a result of this condition: Year 11: _____ Year 12: _____ Other: _____

2. Please describe the impact of this medical condition/disability on the applicant's academic performance. You may wish to include your statement as an attachment.

3. Indicate any adjustments made for this student:

- ☐ No adjustments made
- ☐ Additional time to complete tasks
- ☐ Extensions for assignments
- ☐ Exemption from assessment
- ☐ Re-scheduling exams
- ☐ Counselling/school support
- ☐ Specialised equipment for disability
- ☐ Reader/scribe for physical impairment
- ☐ Variation in tasks for sensory/physically impaired
- ☐ Modified curriculum
- ☐ Other _____

4. What was the extent of this adjustment?

- ☐ Applied to all subjects
- ☐ Other _____

5. Taking into account the adjustments made above, what was the severity of impact on the student's academic performance. Please consider whether this instance is less or more serious than other students applying under this category, and apply ratings accordingly.

0	1	2	3	4	5	6	7
◉	○	○	○	○	○	○	○

No impact **Profound & Chronic Impact**

☐ Documentation attached

Name of education provider: _____

School representative: _____ Position: _____

School representative to sign: _____ Date completed: _____

Please pass this document to your Primary Health Care Provider for completion.
PATIENT STATEMENT on page 3 of this application form.

APPLICANT DETAILS

Name:

QTAC Application Number:

PATIENT STATEMENT

(health care professional to complete – applicants must not write in this section)

1. Medical condition/disability: _____

Date of diagnosis: _____

Describe the condition affecting the patient:

How long has the patient been affected by the medical condition/disability?

☐ Less than 6 months
☐ 6–11 months
☐ 1–2 years
☐ More than 2 years

To your knowledge, what treatment has the patient received?

How long has the patient been receiving treatment?_____

How often has this treatment been? daily/weekly/monthly/irregularly/other _____

When did this treatment end? _____

2. Impact on ability to study

Indicate the impact of the medical condition/disability on the patient's ability to study by ticking the appropriate box:

☐ Extreme
☐ Considerable
☐ Moderate
☐ Slight
☐ Not at all

Please describe the nature of the impact (eg John would have had trouble concentrating.)

3. Details of registered health professional
(medical practitioner, psychiatrist, psychologist or specialist not related to the applicant)

Name of health care professional: _____

Position/occupation: _____ Reg/Provider No: _____

Name of organisation (eg Mater Hospital): _____

Signature: _____ Date: _____

Attach this to documentation and return to QTAC

Upload your documentation to your online application at https://applications.qtac.edu.au.