



## **CARER REGISTRATION FORM**

For students who are a Carer of someone who has a disability, medical condition, mental illness or frail and aged as defined by the Carer Recognition Act 2010. The information provided will remain confidential and will be used by the Student Welfare Service, to determine eligibility of a Carer Verification Certificate.

PLEASE NOTE: Caring responsibilities that do not fall within the definition of the Carer Recognition Act 2010 will not be considered for a Carer Verification Statement.

### **PERSONAL DETAILS (to be completed by the student)**

Date: \_\_\_\_\_

Full name: \_\_\_\_\_

Student ID number: \_\_\_\_\_

Mobile: \_\_\_\_\_

Campus: \_\_\_\_\_

Course name: \_\_\_\_\_

Relationship to the person that is being cared for:

\_\_\_\_\_

**THE REMAINDER OF THIS FORM IS TO BE COMPLETED BY THE HEALTH PRACTITIONER OF THE PERSON THAT IS BEING CARED FOR**

Is the applicant a carer of a person who has a disability, medical condition, mental illness or is frail and aged as defined by the Carers Recognition Act? (tick box)

☐ YES

☐ NO

Is the condition of the person whom the student is providing care for;

☐ Permanent/Long term

☐ Temporary/Short term (if so a timeframe must be stated)

Timeframe \_\_\_\_\_

Please indicate the nature of care provided by the carer;

☐ Physical/personal care

☐ Activities of daily living/managing personal affairs

☐ Attending appointments

☐ Other (provide details)

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**Please indicate how many hours the carer is likely to spend on caring responsibilities;**

☐ **Per week** \_\_\_\_\_

☐ **Per day** \_\_\_\_\_

☐ **Other (provide details)**

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**Please indicate how the caring responsibilities may impact on the carer's studies;**

☐ **Submitting assessments on time**

☐ **Tutorial attendance**

☐ **Student placement considerations (placement to be located within 60 mins of residential address)**

☐ **Other (provide details)**

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### **HEALTH PRACTITIONER DETAILS**

**Name of practitioner:** \_\_\_\_\_ **Provider number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Contact telephone:** \_\_\_\_\_

**Practitioners Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Provider's stamp

MUST BE AFFIXED HERE

**If a stamp is not available, a signed declaration of a provider number on a practitioner's letterhead is to be attached to this application**