



REPUBLIC OF SOUTH AFRICA

## FORM 4

[Regulation 12]

## APPLICATION FOR ASSISTANCE IN RESPECT OF ASSISTIVE DEVICE

PROMOTION OF NATIONAL UNITY AND RECONCILIATION ACT, 1995 (ACT 34 OF 1995)

**READ THIS FIRST**

1. This application form must be completed if you have a disability and require assistance in respect of an assistive device.
2. Should the nature of your disability change over the term of study, and if this impacts directly on your ability to participate in your educational programme, then you will need to submit updated details and a full medical/rehabilitation report from a certified professional.
3. This application form must be completed by a registered medical doctor or other appropriately qualified professional, and it is your responsibility to have this form completed as indicated.
4. Please ensure that this form is duly completed, signed, and accompanied by all the required supporting documents, as missing or omitted information will delay the finalisation of the application or your application will not be considered.
5. This application form and supporting documentation will remain confidential.

A. PARTICULARS OF APPLICANT			
1. Title:			
2. Surname:			
3. First Names:			
4. ID number:		5. Date of birth:	
6. Gender:	*Male / Female /Other		
7. Student number:			
8. Contact details:	*Home address / Home address of other person (if applicable): <i>(State below the address where you live and to which mail may be sent. If you do not have an address, state the address of another person who can be contacted, e.g. place of worship, school, community leader, etc..)</i>		
	Postal address / Postal address of other person (if applicable):		
9. Telephone Numbers:	Home:	Work:	Cell no:

10. Please indicate your disability in the section below and give details of the disability		
DISABILITY	INDICATE WITH X	DETAILS OF DISABILITY
Hearing (Deaf, hard of hearing, hearing deaf and hearing impaired)		
Vision (Blind, Low Vision, Deaf Blind)		
Mobility/Motor (physical function e.g. impaired upper limb or lower limb functionality, quadriplegia, paraplegia)		
Neurological and neurodevelopmental impairments (e.g. cerebral palsy, autism, foetal alcohol syndrome, traumatic head injury, stroke, epilepsy, attention and hyperactivity disorder, dyslexia, down syndrome, dyscalculia, dysgraphia) and Behaviour and social skills (caused by e.g. abuse, neglect, trauma, malnutrition)		
Cognition and learning – moderate, severe and profound intellectual disability		
Communication – little or no functional speech		
Health (diabetes, chronic conditions, mental health e.g. depression, schizophrenia, bipolar disorder)		
11. Please provide further details if you have a disability not mentioned above <b>AND</b> provide a medical report from a registered medical doctor or other appropriately qualified professional regarding this disability:		
<hr/> Signature of applicant or the person completing the form on behalf of the person who needs assistance		<hr/> Date

<b>B. PARTICULARS OF REGISTERED MEDICAL DOCTOR OR QUALIFIED PROFESSIONAL</b>			
<b>1. Title:</b>			
<b>2. Surname:</b>			
<b>3. First Names:</b>			
<b>4. Speciality:</b>			
<b>5. Telephone Numbers:</b>	<b>Home:</b>	<b>Work:</b>	<b>Cell no:</b>
6. How long have you been the applicant's doctor (or qualified professional person) ? .....			
7. On which date did the applicant first consult you in connection with this disability: .....			
8. On which date did the applicant last consult you in connection with this disability.....			
9. Please provide the diagnosis applicable to the applicant and how it disables the applicant: ..... .....			
10. Please indicate how the disability impacts on the teaching and learning process of the applicant: ..... ..... .....			
11. Does the applicant use an assistive device : <span style="float: right;"><b>Yes</b> / <b>No</b></span> If yes, please – (a) specify particulars of the assistive device: .....			
(b) indicate why such device needs to be replaced: .....			
12. Please indicate which assistive device is now required: .....			
13. Please indicate whether the applicant will benefit from the assistive device that is now required: .....			
14. Please indicate how the applicant will benefit from the assistive device: ..... ..... .....			
15. Please indicate the relevance of the assistive device in relation to the particular qualification for which the applicant has registered: .....			
16. Does the applicant require assistance in the form of human support? <span style="float: right;"><b>Yes</b> / <b>No</b></span> If yes, please – (a) provide details of the form/s of human support needed: .....			
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(b) indicate whether the human support needed is required in order to study for the particular qualification for which the applicant has registered:

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(c) indicate whether the person providing human support will be required to stay/live with the applicant:

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17. Please provide any other information and/or comments in respect of the applicant's disability that is relevant and may assist in assessing the applicant's claim for assistance in respect of an assistive device

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**Declaration:** I hereby declare and warrant that the information given above is factual, true and correct and that no material information has been withheld nor any relevant circumstances omitted.

.....  
Signature

.....  
Date

*(Doctor or qualified professional person  
must affix his/her stamp here  
to confirm their details)*