NSW GOVERNMENT Education

Willmot Public School
Dharug Country
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WILLMOT NSW 2770
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Externally Funded Service Provider Application & Declaration

External Provider Details

Therapist Name: _____

Organisation: _____

Email: _____ **Phone:** _____

Student Name: _____

Type of Therapy: ☐ Speech Pathologist ☐ Physio ☐ OT
☐ Other (advise): _____

Timeframe & Sessions

School term: ☐ Term 1 ☐ Term 2 ☐ Term 3 ☐ Term 4

Type: ☐ Observation Only (one off) ☐ Series of sessions

If series of sessions: ☐ Weekly ☐ Fortnightly ☐ Other (advise):_____

Location of delivery: ☐ Classroom ☐ Other Room ☐ Playground
☐ Other (advise):_____

Length of session: _____

Preferred Days / Times: _____

Preferred Start Date:

Time and day to be determined in consultation with Learning and Support Team / Teacher / Therapist. Parents to be kept up to date and notified of any changes.

Outline of therapy to be provided on site and expected outcomes:

_____

_____

_____

THERAPIST DECLARATION

☐ I agree to provide regular feedback to the Willmot PS Learning and Support Team regarding the above listed student.

☐ I understand that the Willmot PS Learning and Support Team will regularly review the appropriateness of therapy and the type of therapy provided at school

☐ I understand that I am required to advise the parent/ carer and Willmot Public School if I will be absent on the day therapy sessions are scheduled at the school.

☐ I understand that the parent / carer of the student is responsible for notifying me if the student will be absent on the day therapy sessions are scheduled at the school.

☐ I understand that any agreement to provide therapy on-site will be for the agreed timeframe and valid only for that particular calendar year. I understand that a new Externally Funded Service Provider Application & Declaration will need to be completed each year.

☐ I understand that any agreement to provide therapy on-site is reliant on available school resources, and as such, room availability and/or approval to provide therapy on site is subject to change.

Therapist Name: _____

Therapist Signature: _____ **Date:** _____

Externally Funded Service Provider Application & Declaration

External Provider Requirements

The following documentation is required by therapist prior to request being considered. It is the responsibility of the therapist to complete and provide all necessary documentation to the school before the approval of this request.

- ☐ Completed Externally Funded Service Provider Application & Declaration
- ☐ Completed Declaration for Child Related Work – Specified Volunteers and Child-Related Contractors. (Must be completed each calendar year)
- ☐ Show government issued photo identification with date of birth details
- ☐ Complete the Willmot Public School WWC Declaration
- ☐ Completed the External Provider Engagement Agreement.
- ☐ Provide evidence of Currency for:
  - Workers Compensation, or, if the provider is an individual or sole trader performing, the work themselves, evidence of personal insurance cover in the event they have an injury.
  - Professional Indemnity (no less than $2 million)
  - Public Liability (no less than $20 million)
- ☐ Provide certificate showing proof of completion of DoE Child Protection Awareness Training including mandatory reporter procedures http://cpat.learnbook.com.au/ or a suitable alternative training program developed by the provider for its staff, within the last year
- ☐ Provide evidence of relevant health care training (first aid, CPR, ASCIA) where a school determines that the Provider should undertake specific health care training. Mandatory for all providers working with a student who has an ASCIA Allergy / Anaphylaxis plan.

This request must be submitted to the school office will all documentation for consideration at the next Learning and Support Team meeting. Parent / Carers and therapists will be notified of the outcome following the meeting.

Completed by Willmot Public School LST Staff / Delegate

Learning and Support Team Evaluation & Outcome

- ☐ All required documentation supplied
- ☐ Screening completed and clear status received
- ☐ Therapy session / room / resource availability
- ☐ Therapy / Intervention Goals (link PLP/IEP Goals where relevant):

_____

_____

_____

Outcome: ☐ **Approved** ☐ **Not Approved**

Reason/s: _____

Day / Time: _____ ☐ **Weekly** ☐ **Fortnightly**

Room / Resource Allocated: _____

Staff Name: _____ **Signature:** _____ **Date:** _____