

Inclusive Education Resource Centre School Membership Request

Date: _____

School: _____

Principal: _____

Head of Special Education/Learning Support: _____

Email: _____ Phone: _____

Number of verified students identified at time of membership agreement:

<u>Verified Disability Category</u>	<u>Number of Male Students</u>	<u>Number of Female Students</u>
Autism Spectrum Disorder		
Hearing Impairment		
Intellectual Impairment		
Physical Impairment		
Speech-Language Impairment		
Vision Impairment		
Social Emotional		

Expected number of teachers who will use ARC resources:

Times/days/length of visit most convenient for these teachers to borrow from mobile service:

Any other relevant information that will help us develop our delivery schedule:

Please indicate which level of membership your school will require. Please note number of items is PER SCHOOL, PER VISIT...not per teacher. Teachers divide

Membership Structure:	<input type="checkbox"/> 10 items per loan: \$200 per year (only one verified student with a disability)
	<input type="checkbox"/> 15 items per loan: \$240 per year
	<input type="checkbox"/> 20 items per loan: \$300 per year
	<input type="checkbox"/> 30 items per loan: \$350 per year
	<input type="checkbox"/> 40 items per loan: \$400 per year
Cluster Memberships:	<input type="checkbox"/> 20 items per loan: \$300 per year (2 schools, each with one verified SWD)
	<input type="checkbox"/> 25 items per loan: \$350 per year (2 schools, one with one SWD, one with more)
	<input type="checkbox"/> 30 items per loan: \$400 per year (2 schools both with more than one SWD)

Online Catalogue: <http://arc.cmeweb.libcode.com.au/>

School is requesting:

- Resource selection via standard mobile visit once per term
- Resource selection via standard mobile visit twice per term
- Resource selection in person from 92 Little St North Cairns
- Resource selection via online catalogue for delivery via mobile service

Principal's acknowledgement of receipt of an NSO-funded service:

Principal Name

Principal Signature

OR

Principal's Delegate Name

Principal's Delegate Signature

Payment via invoice only

School contact person for invoicing:

Name: _____

Role: _____

Telephone: _____

Email: _____

Please return this form to ARC Disability Services

E: info@arcinc.org.au

Office Use Only:

Date Received: _____ Received by: _____ Receipt No: _____

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