**Equipment Program order number**:

Client name: Client number:

Address modified:

When the building work has been completed to the agreed specifications, please complete this form. If you have any concerns with an aspect of the modifications completed, please discuss these with your prescribing clinician and the building consultant and record on this form.

**Property owner to complete:**

I confirm that the modifications have been completed to the specifications and plans. ❑ Yes ❑ No

I am satisfied with the standard of work. ❑ Yes ❑ No

Comments:

Signature of property owner: Date:

Print Name:

**Client to complete**:

I am able to satisfactorily use the facilities that have been modified ❑ Yes ❑ No

Comments:

Signature of client: Date:

Print Name:

**Consultant to complete:**

I confirm that the building work has been completed in accordance to the specifications and plans and the relevant building codes and regulations. ❑ Yes ❑ No

Comments:

Signature of consultant: Date:

Print name:

**Prescribing clinician to complete:**

I confirm that the building work has been completed in accordance to the specifications and meets the client’s clinical needs. ❑ Yes ❑ No

Comments:

Signature: Date:

Print Name:

**Once agreement is signed, return to Equipment Program:** **DHSEquipmentProgram@sa.gov.au**