SG ENABLE
Inclusive society. Enabled lives.

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HOSPITAL-TO-WORK APPLICATION FORM

Eligibility criteria for employment and training assistance are as follows:

- Singapore Citizen or Singapore Permanent Resident
- Aged 16 and above
- Have certified acquired disability (Intellectual, Hearing, Physical or Visual)

Please attach a copy of the following documents during submission of this application:

- Clear photocopy of the applicant's **Medical Report/ Discharge Summary/Memo on Disability**
- Clear photocopy of the applicant's **NRIC (Front and Back)**
- Clear photocopy of the applicant's **Physiotherapy / Occupational / Speech Therapy / Social Report (if applicable)**

A. APPLICANT'S PARTICULARS		
Name:		**NRIC:**
Gender: ☐ Male ☐ Female	**Date of Birth:** **Age:**	**Citizenship:** ☐ Singapore Citizen ☐ Singapore PR
Address:		**Home Telephone No:** **Mobile Phone No:** **Office Phone No:**
Postal Code: ☐☐☐☐☐☐		
E-mail Address:		**Religion:**
Race: ☐ Chinese ☐ Malay ☐ Indian Others: ___________________________		
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Highest Educational Level: ☐ No Formal Education ☐ Primary ☐ Secondary ☐ GCE 'N' Level ☐ GCE 'O' Level ☐ GCE 'A' Level ☐ ITE Certificate ☐ Diploma ☐ Degree ☐ Postgraduate ☐ Others: Other Professional Qualifications (if, any):		**Language: Spoken Written** English ☐ ☐ Mandarin ☐ ☐ Malay ☐ ☐ Tamil ☐ ☐ Others:
Current Employment Status: ☐ Employed ☐ Unemployed		

B. SKILLS
PC Skills: ☐ MS Word ☐ MS Excel ☐ MS PowerPoint ☐ Email ☐Internet
Other Skills: ____

C. DISABILITY, MOBILITY AND ASSISTIVE AIDS

Nature of Disability:

☐Intellectual ☐ Developmental ☐Hearing ☐ Physical ☐Visual

☐ Others, please specify: ☐ Multiple, please specify:

Please elaborate on the condition:

Preferred mode of communication:

☐ Verbal ☐ Lip reading ☐Signing ☐ Written

☐ Communication Devices: ☐ Others: ___________________________

Ability to travel independently:

☐ Yes, please specify mode: ☐ MRT ☐ Bus ☐ Car ☐ Taxi ☐ Others:

☐ No, Please specify reason:

Usage of mobility aids: ☐ No ☐ Yes (Please indicate the aid used): ________________________________

☐ Manual/ Motorised Wheelchair ☐ Prosthesis ☐ Walking Frame ☐ Rollator

☐ Walking Stick ☐ Quad Stick ☐ Others:

Usage of hearing aids: ☐ No ☐ Yes (Please specify):

Usage of visual aids: ☐ No ☐ Yes (Please specify):

D. PARTICULARS OF IMMEDIATE FAMILY MEMBERS

Name	Age	Relationship	Staying Together [Yes/No]	Marital Status	Occupation

E. EMERGENCY CONTACT

Name	Relationship	Contact Detail

F. EDUCATION INFORMATION

Please provide your highest qualification.

Qualification Obtained	Period of Study		Name of School
	From (year)	To (year)	

G. EMPLOYMENT HISTORY

Please indicate current or three most recent jobs.

Organization Name	Period of Work (month/year)		Position held	Main Job Duty & Last Drawn Salary
	From	To		

H. SUPPORT HISTORY

Have you receive any health (e.g Rehabilitation) or community (e.g Social Service Office, Family Service Centre) services?

☐ No ☐ Yes, please specify below:

Agency / Service Provider	Period of Engagement		Period of Assistance
	From (month/year)	To (month/year)	

I. OTHERS

Have you been convicted in court before?	☐ Yes	☐ No
Have been declared bankrupt/ undischarged bankrupt?	☐ Yes	☐ No

I declare to the best of my knowledge and belief that the particulars furnished by me and/or the care person are true and correct.

- I have been informed that in the course of processing my application, it may be necessary for the referring agency to disclose relevant information pertaining to me / my household to other relevant agencies.
- I understand that the disclosure of such information is necessary to facilitate my application. I hereby give my consent for the disclosure of such information to the relevant agencies to facilitate consideration of my application and/or the administration and provision of services and schemes to me and/or data analysis, evaluation and policy formulation, in which I shall not be identified as specific individual.
- I understand that the application will be subjected to assessment by SG Enable to assess my suitability for the programme.
- I shall abide by the terms and conditions attached in Annex B laid down, should I be accepted and contracted to employment.

____ ____

Signature of *Applicant/ Applicant's Caregiver's Name

____ ____

NRIC Date

* Please delete accordingly.

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Participation in Hospital-to-Work Programme for Persons with Acquired Disabilities

DECLARATION AND CONSENT

1. I consent to providing my particulars and personal details to service providers as necessary for my participation in the Hospital-To-Work Programme.

2. I understand that the role of the service provider is to provide transition support for persons with acquired disabilities to return back to work.

3. I declare to the best of my knowledge that the particulars provided to service providers are true and correct.

4. I understand that I will have to comply with the requirements for the application of respective schemes for assistance or subsidies, where relevant, and my eligibility for these aids may be assessed independently from my participation in the Programme. It may be necessary for service providers to disclose / transfer relevant information pertaining to me / my household to other relevant agencies in the process of assisting me to access various schemes and aids as necessary.

5. I understand that the disclosure of such information is necessary to facilitate my applications for assistance. I also hereby give my consent for the release / disclosure of such information to the relevant bodies to facilitate consideration of my applications.

6. I also understand that in the event that I am not eligible to participate in the Hospital-to-Work Programme, I may be referred to partner organisations to assist me further.

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Name/ NRIC/ Signature of Applicant/ Date

____

Name/ Signature of Witness/ Date