20 Lengkok Bahru Road, #02-06
Singapore 159053
Infoline : 1800 8585 885
Fax : +65 6226 2366
Email : contactus@sgenable.sg
Website : www.sgenable.sg
Co. Reg. No. 200822425N

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: _____

Driving Licence: Class _____

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			
Are you receiving any health (e.g Rehabilitation) or community (e.g SSO, FSC) 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 bankrupts?	□ 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 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

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.

_____

Name/ NRIC/ Signature of Applicant/ Date

_____

Name/ Signature of Witness/ Date

SG ENABLE

ANNEX A

MEDICAL INFORMATION

(This section is to be filled up by a Medical Doctor or Allied Health Professionals)

Name of Patient:_____ **NRIC No.:** _____

Please tick ☑ where appropriate.

TYPE OF DISABILITY (Multiple selection allowed for multiple disabilities condition)

Diagnosis

☐ Intellectual ☐Physical ☐Visual ☐Hearing ☐Others

Remarks:_____

MEDICAL HISTORY

(a) Psychological or mental disorders

☐ No – *Please move on to Question (b)* ☐ Yes, please specify: ____

Condition: ☐ Mild ☐ Moderate ☐ Severe

(b) Infectious diseases

☐ No – *Please move on to Question (c)* ☐ Yes, please specify: _____

☐ Following up: ☐ Yes ☐ No ☐ Discharged ☐ Defaulted

Date of last follow-up:_____ Hospital / clinic: _____

Condition: ☐ Active or highly contagious ☐ Persistent and asymptomatic

☐ No longer infectious or contagious

(c) Medical conditions

☐ Respiratory: _____ ☐ Neurological disorders: _____

☐ Cardiovascular: _____ ☐ Musculoskeletal: _____

☐ Endocrine / Metabolic: _____ ☐ Dermatological conditions: _____

☐ Other condition(s) not specified above: _____

If any of the above is ticked, please elaborate (e.g. frequency of occurrence): _____

(d) Did patient undergo any surgery within the last two years? If yes, please provide brief details:

	Date	**Surgery done**
☐ No		
☐ Yes		

(e) Is patient currently on any medication?		
□ No □ Yes	**If yes, please specify:**	
	1.	6.
	2.	7.
	3.	8.
	4.	9.
	5.	10.

(f) Does patient have any drug allergies?		
□ No □ Yes	**If yes, please specify:**	
	1.	3.
	2.	4.

(g) Does patient have any regular follow-ups?		
□ No □ Yes	**If yes, please specify:**	
	Types of follow up	**Frequency**

(h) Is patient fit for employment?	
□ No □ Yes	**If yes, please specify:**
	☐ Patient will be medically stable for employment in the next _____ (months).
	☐ Patient is medically stable for employment.
	☐ Patient is medically stable for specific job/work (light duty/non heavy work/carrying work)

(i) Rehabilitation and Therapy

□ The patient **requires** rehabilitation/ therapy.

□ The patient is **fit** to participant in rehabilitation/ therapy.

Precautions/Restrictions during rehabilitation/ therapy :

_____

ASSESOR'S CERTIFICATION - IF APPLICABLE			
			Official stamp of hospital/ clinic:
Name of Assessor		Signature of Assessor	
Date (DD/MM/YYYY)	MCR/ Registration No.	Contact No.	

EMPLOYABILITY AND EMPLOYMENT SERVICE FOR HOSPITAL-TO-WORK PROGRAMME **ANNEX B**

TERMS AND CONDITIONS

1. Eligibility Criteria
   - 1.1 Applicant must be a Singapore Citizen or Singapore Permanent Resident.
   - 1.2 Applicant needs to be aged 16 and above.
   - 1.3 Applicant must be certified of disability.

2. Training
   - 2.1 Applicant will be required to go through work preparation training prior to placement, if required.

3. Matching and Placement
   - 3.1 Applicant may be referred to other related job placement agencies for suitable assistance.

4. Programme Duration
   - 4.1 Clients who are successfully enrolled into the H2W programme will be supported up to 1 year.

5. Safety and Liability
   - 5.1 All clients are expected to take safety precautions when attending job interviews or job trials.
   - 5.2 While all care will be taken, service providers shall not be held liable if the client encounters any accident or mishap while travelling for job interviews or job trials.
   - 5.3 Any accident or mishap that occurs during the job trial and employment period will be managed by the hiring company or organization according to their policy.

6. Suspension and Termination of Service
   - 6.1 In the event that the information provided by the client is false or incorrect, service providers have the right to reject the client's application, withdraw any offer of employment, terminate any employment contract placed by service providers with employers or discharge the client from employment support.

   - 6.2 Service will be withheld from client or terminated under the following circumstances:
     - a) Non-adherence to the terms and conditions set by staff of service providers;
     - b) Defaulting on arranged job interviews and/or rejecting job interview opportunities of up to three (3) occasions;
     - c) Failure to report for work after accepting job offer;
     - d) Threats, verbal and /or physical abuse in any way towards service provider's staff; and
     - e) Nuisance or obscene phone calls / mobile texts / emails or sexual harassment in any for directed to service providers staff. In the event of any such occurrences, a police report may be filed.

7. Database Registry
   - 7.1 Client information will be stored in service provider's database and will be shared with our working partner agencies. Applicant will be made known of these referrals.

8. Feedback Channels
   - 8.1 For any feedback or issue to be raised during job placement period, client may contact service provider's case manager / job coach.

9. Involvement of organizations, partners and agencies
   - 9.1 Client shall abide by the regulations / agreement laid down by the organization / institution involved.