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#02-06

Singapore

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*Co. Reg. No. 200822425N*

# EMPLOYMENT ASSISTANCE APPLICATION FORM

**To Be Eligible For Employment & Training Assistance:**

* Applicant must be Singapore Citizen or Singapore Permanent Resident aged 16 and above with certified permanent disability
* Applicant must provide proof of permanent disability (Medical Report and/or Membership card of Disability Organisations). Applicant may be required to submit the completed Functional Assessment Report provided by SG Enable
* Applicant may be required to complete vocational/psychological assessment(s) and training programmes recommended by SG Enable

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

NRIC (front and back)

Medical Report (on Disability Condition) and/or Membership card for Disability Organisations

Public Transport Concession Card (If any)

Resume (If any)  Educational Certificates (If any)

## REFERRAL SOURCE

|  |
| --- |
| **How did you know about SG Enable?:** |
| Media (News, Radio, Newspaper)  Others (Please specify:      )  Social Media (Please specify:      )  Social Service Agencies (\*AWWA / SADeaf / SAVH / Others:      )  Word of mouth (Friend, Relative) |

## PARTICULARS (as per NRIC)

|  |  |  |
| --- | --- | --- |
| **Name:** | | **NRIC:** |
| **Sex:**  Male  Female | **Date of Birth:**  **Age:** | **Citizenship:**  Singapore Citizen  Singapore PR |
| **Address:**  **Postal Code:** | | **Home Telephone No:**  **Mobile Phone No:**  **Alternative Phone No(s):** |
| **E-mail Address:** | |
| **Race:**  Chinese  Malay  Indian  Others: | | |
| **Marital Status:**  Single  Married  Separated  Divorced  Widowed | | |
| **Employment Status:**  Employed  Unemployed (If unemployed, provide last date of service:      ) | | |

Please tick the appropriate boxes accordingly. \* Delete where applicable

## OTHERS

|  |
| --- |
| **Have you been convicted in court before?**  Yes  No  **Have you been declared bankrupt / undischarged bankrupt?**  Yes  No  **Have you engaged the services of any job placement and support agency within the past 2 years?**  No  Yes, Please specify :  ARC  SPD  MINDS  Others: |

## DISABILITY, MOBILITY AND ASSISTIVE AIDS

|  |
| --- |
| **Nature of Disability:**  Physical  Visual  Hearing  Intellectual  Autism  Multiple, Please specify:        Others, Please specify:  **Please elaborate on the condition (If any):** |
| **Medical History / Diagnosis (If any):** |
| **Preferred mode of communication:**  Verbal  Lip reading  Signing  Written  SMS  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 Wheelchair  Motorized Wheelchair  Walking Frame  Prosthesis  Walking Stick  Quad Stick  Others: |
| **Usage of hearing aids:**  No  Yes (Please indicate the aid used): |
| **Usage of visual aids:**  No  Yes (Please indicate the aid used): |

## EDUCATION INFORMATION

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

## EMPLOYMENT HISTORY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Organisation Name** | **Period of Work**  **(month/year)** | | **Position Held** | **Last Drawn Salary** | **Reason For Leaving** |
| **From** | **To** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Please tick the appropriate boxes accordingly. \* Delete where applicable

## PARTICULARS OF IMMEDIATE FAMILY MEMBERS

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Contact Nos.** | **Occupation** |
|  |  |  |  |  |
|  |  |  |  |  |

### Declaration & Personal Data

1. The information given in this application is true and correct to the best of my knowledge.
2. I have read and understood all of the provisions herein and I hereby give my consent for SG Enable and/or Ministry of Social and Family Development (MSF) to use my or my ward’s personal data including but not limited to my name, NRIC, contact number, mailing and email address as well as other information for such purposes of the present programme run by SG Enable as well as any applicable supplementary programmes at SG Enable’s discretion and the purposes that are set out in SG Enable’s Privacy Policy which can be found on its website at [http://www.sgenable.sg/pages/OurPolicies.apsx](https://www.sgenable.sg/pages/OurPolicies.aspx)  as well as MSF’s Privacy Statement which can be found on its website at [http://www.msf.gov.sg](http://www.msf.gov.sg/).
3. I am aware that SG Enable has the right to recover in full any subsidy disbursed to me arising from this application if I have provided inaccurate information, or withheld any relevant information required for this application.
4. I understand that SG Enable and/or MSF will take all reasonable measures to protect my or my ward’s information from unauthorised access or against loss, misuse or alteration by third parties.
5. I have been advised that I may withdraw my consent to SG Enable and/or MSF in respect of the use of my or my ward’s personal data by providing such reasonable notice to SG Enable and/or MSF as well as to direct any queries I may have, including any request to delete data that have been obtained from me or my ward or from third parties or to opt out of any messages, emails, newsletters or other marketing or promotional materials to me or my ward, to the designated person, email or contact persons as indicated in SG Enable’s Privacy Policy or MSF’s Privacy Statement.

Being the person disclosing the information and making the application for the purposes as set out above, I agree to the above.

Further, I do declare that:

I have made the above statements or representations including any consents or approvals to the above on behalf of the Main Applicant, who is under 18 years of age.

I have made the above statements or representations including any consents or approvals to the above on behalf of the Main Applicant, who is mentally incapacitated.

     

Name of \*Client/Client’s Caregiver NRIC No.

Signature of \*Client/Client’s Caregiver Date

Please tick the appropriate boxes accordingly. \* Delete where applicable