LB 3 Regents Park DC NSW 2143

[redacted]

Dept of Human Services PO Box 7809 Canberra BC ACT Australia 2610
Fax: (613) 62222799

Please quote: [redacted]
Telephone: 13 1673
Office Hours: Mon-Fri 8.00am-5.00pm

Australian Government
Department of Human Services

centrelink

[redacted]

13 March 2013

Dear [redacted]

You have enquired with this office about going overseas for longer than six weeks. You have agreed to undergo an assessment to determine whether you can be paid your Disability Support Pension for an indefinite period of time.

This assessment must be undertaken in Australia. It will consist of a Medical review of your Disability Support Pension qualification and will apply the 1 January 2012 Impairment Tables which may mean you are no longer assessed as qualified for Disability Support Pension.

To commence this assessment, we are sending you 2 forms, a "Work Capacity- Customer Information" form which needs to be completed by you, and the "Medical Report" which needs to be completed by your treating doctor.

When both forms are complete, please post them to the above address. Once we have received these forms, we will organise a Job Capacity Assessment interview so as to determine if you have any future work capacity.

You should return these forms as soon as possible, to allow for a decision to be made. If you no longer wish to undergo this medical assessment, you do not need to return the medical review forms to our office. If you advised of an intended date of travel and your plans have changed, you should phone our office to advise. If you do not return the forms, we will not proceed with the medical assessment.

Please note that if you decline to undergo this medical assessment, you cannot access the indefinite portability provision.

This is an information notice given under social security law.

How to contact us
If you have any questions or would like more information, please call us on **13 1673** between 8.00 am and 5.00 pm Australian Eastern Standard Time, Monday to Friday.

Calls from a home phone to Centrelink 13 numbers from anywhere in Australia are charged at a fixed rate. That rate may vary from the price of a local call and may also vary between telephone service providers. Calls from public and mobile telephones may be timed and charged at a higher rate.

If you prefer, you can leave a message on our answering service and we will return your call.

If you write to us, please give us your telephone number, area code and your Centrelink Customer Reference Number, which is shown at the top of this letter, so we can call you back.

You can also send an email to **international.services@centrelink.gov.au**

Please ensure that we have your reference number, contact address or phone number as we are unable to respond by email as it is not a secure medium.

Yours sincerely

Mark Hanna
Manager
Department of Human Services

Encl.

[redacted]

Centrelink Reference Number [redacted]

Date of issue 13/03/2013

RETURN DATE: 13/04/2013

Human Services phone number **131 673**

Return address

[redacted]

International Services
Reply Paid 7809
CANBERRA BC ACT 2610

Returning your form
Please fold the form and place it in the **reply paid envelope.**

fold here

Australian Government
Department of Human Services

centrelink

Medical Report

Disability Support Pension
Review for portability

Information for the customer and the doctor

This Medical Report has been issued by the Department of Human Services so we can gather additional medical information.

The Medical Report must be fully completed by you and a treating doctor or specialist. This information will help us in determining:

- income support eligibility
- if the customer is eligible to receive payments indefinitely while outside Australia
- if the customer may benefit from a program of support, for example, rehabilitation or training
- if the customer is eligible to enter the Supported Wage System.

Instructions for the customer

It is important that you take the time to read all of this information. Your details are updated regularly to make sure your payment is correct and to identify any help we can give you.

1. **Section A** To be completed by you

   Section B To be completed by a doctor

2. **Make an appointment with the doctor or specialist**
   Please read the instructions at the front of Section B before making the appointment.

3. **Fill in the details about you in Section A**
   If you need help filling in the form or getting a report from your doctor, call us on **132 717**.
   To speak to us in languages other than English, call **131 202**.
   If you have a hearing or speech impairment call our **TTY service** Freecall™ **1800 810 586**.
   A TTY phone is required to use this service.

4. **Return Section A to us**
   Return it to us in one of the enclosed reply paid envelopes **as soon as possible**. Include a copy of any reports relevant to your medical condition that you have not given to us before.

5. **Give Section B to the doctor with the other reply paid envelope**

6. **If the doctor gives this report back to you**
   Return it to us **as soon as possible** in the other reply paid envelope. Otherwise, ask the doctor to send it back to us in the reply paid envelope.
   Your doctor will not be able to submit this report to us through a secure online facility.

IMPORTANT

This request is a notice given under section 63 of the *Social Security (Administration) Act 1999*. This means that both Section A and Section B must be returned to us before the return date shown at the top of this form. If both sections are not returned within this time, your payment may be stopped under section 80 of the *Social Security (Administration) Act 1999*.

[redacted]

This page has been left blank intentionally.

Australian Government
Department of Human Services

centrelink

Medical Report

Disability Support Pension
Review for portability

Section A
You

Please use black or blue pen.

1 Do you need an interpreter when dealing with us?
This includes an interpreter for people who have a hearing or speech impairment.

No ☐ ▶ *Go to 3*
Yes ☐ ▶ *Go to next question*

2 What is your preferred spoken language?

3 What is your preferred written language?

4 List any disabilities, illnesses or injuries you have

5 Give details about the current treatment for your disabilities, illnesses or injuries (e.g. medication, physical therapy, counselling, etc.)

6 Are you expecting to have an operation in the near future?

No ☐ ▶ *Go to next question*
Yes ☐ ▶ Expected date
/ /
▶ *Go to next question*

7 Are there any doctors (apart from the doctor completing the Medical Report), specialists or other professionals who could tell us about your disabilities, illnesses or injuries (e.g. counsellor, social worker, Employment Services Provider, psychologist, community health worker, physiotherapist, rehabilitation provider)?

No ☐ ▶ *Go to next question*
Yes ☐ ▶ Name

Profession

Address

Postcode

Phone number ( )

If you have more than one professional to list, attach a separate sheet with details.

Attach any professional's reports you have that are relevant to your claim.

8 Are you currently employed?

No ☐ *Go to next question*
Yes ☐

9 Are you interested in referral to services or programs to help you find work?

No ☐ *Go to next question*
Yes ☐

The Australian Government provides a wide range of services to help people get ready for work, to find a job and stay in employment.

These services provide specialised help for people with a disability, injury or health condition.

People receiving Disability Support Pension do not have to pay for these services and participation in a program does not effect pension payments.

If you are offered help from one of these services, you can choose whether you wish to accept. If you start in a program, you will be encouraged and supported to keep going, but you can stop taking part at any time.

10 Did someone else help you fill in this form?

No ☐ *Go to next question*
Yes ☐ Why did you need help to complete the form?

11 Do you want another person or organisation to enquire or act on your behalf when dealing with us?

No ☐ *Go to next question*
Yes ☐ You will need to complete and attach an ***Authorising a person or organisation to enquire or act on your behalf*** form (**SS313**). If you do not have this form, go to our website **humanservices.gov.au/nominees** or call us on **132 717**.

12 Privacy and your personal information

Centrelink, Medicare Australia, Child Support and CRS Australia are services within the Australian Government Department of Human Services (Human Services).

Your personal information is protected by law, including the *Privacy Act 1988*. Your information is collected for Social Security, Family Assistance, Medicare, Child Support and CRS purposes. This information may be required by the powers provided within each services' legislation or voluntarily given by you when you apply for services or payments. Your information will be used for the assessment and administration of payments and services. Your information may also be used within Human Services, where you have provided consent or it is required or authorised by law. Human Services may disclose your information to Commonwealth departments, other persons, bodies or agencies ONLY where you have provided consent or it is required or authorised by law. Where necessary Human Services or your assessor may contact your treating doctor or specialist to clarify information provided about your medical conditions.

You can get more information about privacy by going to our website **humanservices.gov.au/privacy** or requesting a copy of the full privacy policy at one of our Service Centres.

13 Statement

I declare that:

- the information provided in this form is complete and correct.

I understand that:

- this information is used to determine my eligibility for income support payment and may be used to determine my suitability for employment assistance, rehabilitation, training and participating in other support activities.
- giving false or misleading information is a serious offence.
- Human Services can make relevant enquiries to ensure I receive the correct entitlement.

Your signature

Date / /

[redacted]

Centrelink
Reference Number

Date of issue 13/03/2013

RETURN DATE: 13/04/2013

Human Services
phone number

Return address

International Services
Reply Paid 7809
CANBERRA BC ACT 2610

Returning your form
Please fold the form and place it in the **reply paid envelope.**

fold here

Australian Government
Department of Human Services

centrelink

Medical Report

Disability Support Pension
Review for portability

Section B
Doctor

Instructions for the customer

1. **Fill in Section A and return it to us in one of the reply paid envelopes.**

2. **Contact your doctor or specialist and make an appointment to have the Medical Report Section B completed.**
   Make sure the doctor and their receptionist know that you will need this report completed, as a long consultation may be required. If your doctor does not bulk bill, your consultation fee may be more than usual because of the extra time taken to complete the report.

3. **Attend the appointment with your doctor or specialist.**

4. **Give Section B of this report, and a reply paid envelope, to the doctor to complete.**
   Your doctor will not be able to submit this report to us through a secure online facility.

Information for the doctor

This information will help us in determining:
- income support eligibility
- if the customer is eligible to receive payments indefinitely while outside Australia
- if the customer may benefit from a program of assistance or training
- if the customer is eligible to enter the Supported Wage System.

Completing this report

In this report you will be asked to provide information about your patient's medical condition(s). Please complete all the required questions in this report.

If you need more information in order to complete the Medical Report call us on **132 150**.

Returning this report

You can give this report and any attachments to your patient or you can return it/them to us in the reply paid envelope issued to the customer with this form. Alternatively, post this form to

International Services
Reply Paid 7809, CANBERRA BC ACT 2610.

Reimbursement for Services

We have asked your patient to let you (and your receptionist) know at the time of making their appointment that they require you to complete this report. This is to ensure that you have sufficient time for the examination and completion of the report. The time taken to complete this report counts towards the length of the consultation. You can claim it as a long consultation.

For information about confidentiality and disclosure of information

See questions 9 and 12.

Thank you for your assistance.

[redacted]

Please use black or blue pen.

1 This person has been: my patient since / /

a patient at this practice since / /

2 Does the patient have a medical condition that may significantly reduce their life expectancy?

No ☐ ▶ ***You do not need to complete question 3. Go to 4***

Yes ☐ ▶ Diagnosis

▶ *Go to next question*

3 Is the average life expectancy of a person with this condition shorter than 24 months?

No ☐ ▶ *Go to next question*

Yes ☐ ▶ ***You do not need to complete questions 4 to 8. Go to 9***

4 Does the patient have one or more medical conditions that have a SIGNIFICANT IMPACT on their ability to function (e.g. endurance, walking, sitting, standing, performing daily activities, handling and manipulating objects, bending, self-care, concentration, attention, communication, hearing, vision, continence, consciousness)?

No ☐ ▶ ***You do not need to complete question 5. Go to 6***

Yes ☐ ▶ *Go to next question*

5 Give details about the conditions that have a SIGNIFICANT IMPACT on the patient's ability to function.

List conditions in order of degree of impact on ability to function, starting with the condition with the most impact.

(see next page)

Condition 1—*condition with most impact*

Diagnosis

A Diagnosis

Date of onset (if known) / /

The diagnosis is:

Presumptive ☐ Are further investigations/tests planned to confirm the diagnosis?

No ☐
Yes ☐

Confirmed ☐ Is the diagnosis supported by **further** specialist opinion?

No ☐
Yes ☐ Give details below

Psychiatrist/ Clinical Psychologist ☐ Name

Audiologist/Ear, Nose and Throat specialist ☐ Name

Ophthalmologist ☐ Name

Other ☐ Name and specialty

Are the relevant specialist reports available?

No ☐
Yes ☐ Attached ☐
Will provide on request ☐

Date of diagnosis / /

Treatment

B Current treatment

Provide details of all current treatment for this condition (e.g. hospitalisation, surgery, medication and dosage, counselling, physical therapy, rehabilitation, frequency of treatment)

Treatment	Date commenced
	/ /
	/ /
	/ /
	/ /
	/ /
	/ /

Condition 1—*continued*

Treatment—continued

C Past treatment

Provide details of past treatment for this condition (e.g. hospitalisation, surgery, medication and dosage, counselling, physical therapy, rehabilitation, frequency of treatment)

Treatment type	Date commenced	Duration of treatment
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

D Specialist consultation

Have you or another doctor from your practice previously referred this patient to a specialist?

No ☐

Yes ☐ Give details below

Name	Specialty	Date of consultation
		/ /
		/ /
		/ /
		/ /

E Future/planned treatment

Provide details of any further scheduled or proposed treatment with estimates of likely dates of commencement and expected duration.

F Patient's compliance with recommended treatment

Very compliant ☐ Usually compliant ☐ Rarely compliant ☐ Uncertain ☐

Detail any issues related to accessing or undertaking suitable treatment that affect the level of compliance.

Clinical features

G Current symptoms

Describe current symptoms. Be specific and include severity, frequency and duration.

Note: symptoms are those persisting **despite** treatment, aids, equipment or assistive technology.

Condition 1—*continued*

Clinical features—continued

H History

Provide details of underlying causes and contributing factors, results and dates of investigations/procedures and specialist consultations (e.g. radiology, pathology, RFTs, specialist reports).

Impact on ability to function

i Details about how this condition and its treatment currently impact on the patient's ability to function

Be specific and consider the impacts on:

- endurance
- movement/dexterity (e.g. walking, bending, sitting, standing, lifting/carrying/manipulating objects)
- neurological/cognitive function (e.g. concentrating, decision making, memory, problem solving)
- functions of consciousness (details of involuntary loss of consciousness or altered consciousness (e.g. seizures, migraines))
- behaviour, planning, interpersonal relationships
- sensory function (e.g. seeing, hearing, speaking)
- digestive, reproductive, continence function
- need for care (e.g. support in daily living, support accommodation or nursing home/hospital care).

J The current impact of this condition on the patient's ability to function is expected to persist for:

Less than 3 months ☐
3-24 months ☐ ***Go to K***
2–5 years ☐
More than 5 years ☐ ***Go to L***

K Within the next 2 years the effect of this condition on the patient's ability to function is expected to:

Resolve ☐ Significantly improve ☐ Slightly improve ☐ Fluctuate ☐
Remain unchanged ☐ Deteriorate ☐ Uncertain ☐

L Within the next 5 years the effect of this condition on the patient's ability to function is expected to:

Improve ☐ Remain unchanged ☐ Deteriorate ☐

Provide details

For a second condition that has a significant impact on ability to function, go to Condition 2, on the next page.

If there are no other conditions that have a significant impact on ability to function, go to question 6 on page 9.

Condition 2

Diagnosis

A Diagnosis

Date of onset (if known) / /

The diagnosis is:

Presumptive ☐ Are further investigations/tests planned to confirm the diagnosis?

No ☐
Yes ☐

Confirmed ☐ Is the diagnosis supported by **further** specialist opinion?

No ☐
Yes ☐ Give details below

Psychiatrist/ Clinical Psychologist ☐ Name

Audiologist/Ear, Nose and Throat specialist ☐ Name

Ophthalmologist ☐ Name

Other ☐ Name and specialty

Are the relevant specialist reports available?

No ☐
Yes ☐ Attached ☐
Will provide on request ☐

Date of diagnosis / /

Treatment

B Current treatment

Provide details of all current treatment for this condition (e.g. hospitalisation, surgery, medication and dosage, counselling, physical therapy, rehabilitation, frequency of treatment)

Treatment	Date commenced
	/ /
	/ /
	/ /
	/ /
	/ /
	/ /

Condition 2—*continued*

Treatment—continued

C Past treatment

Provide details of past treatment for this condition (e.g. hospitalisation, surgery, medication and dosage, counselling, physical therapy, rehabilitation, frequency of treatment)

Treatment type	Date commenced	Duration of treatment
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

D Specialist consultation

Have you or another doctor from your practice previously referred this patient to a specialist?

No ☐

Yes ☐ ▶ Give details below

Name	Specialty	Date of consultation
		/ /
		/ /
		/ /
		/ /

E Future/planned treatment

Provide details of any further scheduled or proposed treatment with estimates of likely dates of commencement and expected duration.

F Patient's compliance with recommended treatment

Very compliant ☐ Usually compliant ☐ Rarely compliant ☐ Uncertain ☐

Detail any issues related to accessing or undertaking suitable treatment that affect the level of compliance.

Clinical features

G Current symptoms

Describe current symptoms. Be specific and include severity, frequency and duration.

Note: symptoms are those persisting **despite** treatment, aids, equipment or assistive technology.

Condition 2—*continued*

Clinical features—continued

H History

Provide details of underlying causes and contributing factors, results and dates of investigations/procedures and specialist consultations (e.g. radiology, pathology, RFTs, specialist reports).

Impact on ability to function

i Details about how this condition and its treatment currently impact on the patient's ability to function

Be specific and consider the impacts on:

- endurance
- movement/dexterity (e.g. walking, bending, sitting, standing, lifting/carrying/manipulating objects)
- neurological/cognitive function (e.g. concentrating, decision making, memory, problem solving)
- functions of consciousness (details of involuntary loss of consciousness or altered consciousness (e.g. seizures, migraines))
- behaviour, planning, interpersonal relationships
- sensory function (e.g. seeing, hearing, speaking)
- digestive, reproductive, continence function
- need for care (e.g. support in daily living, support accommodation or nursing home/hospital care).

J The current impact of this condition on the patient's ability to function is expected to persist for:

Less than 3 months ☐ ***Go to K***
3-24 months ☐
2–5 years ☐ ***Go to L***
More than 5 years ☐

K Within the next 2 years the effect of this condition on the patient's ability to function is expected to:

Resolve ☐ Significantly improve ☐ Slightly improve ☐ Fluctuate ☐
Remain unchanged ☐ Deteriorate ☐ Uncertain ☐

L Within the next 5 years the effect of this condition on the patient's ability to function is expected to:

Improve ☐ Remain unchanged ☐ Deteriorate ☐

Provide details

If there are more than 2 conditions that have a **significant impact** on ability to function, attach a separate sheet with details.

6 Does the patient have any other medical conditions that are generally well managed and that cause minimal or limited impact on ability to function?

No ☐ *Go to next question*

Yes ☐ Give details below

7 Is there any other information that you would like to provide?

No ☐ *Go to next question*

Yes ☐ Give details below

8 Do you wish to provide medical certificate details on this report?

No ☐ *Go to next question*

Yes ☐ **Certification**

I examined this person on / /

In my opinion this person is temporarily unfit for work or study

from / / to / /

In my opinion this person can ☐ cannot ☐ currently do their usual work or study or any other work for 8 hours or more per week.

9 Release of medical information

The *Freedom of Information Act 1982* allows for the disclosure of medical or psychiatric information directly to the individual concerned. If there is any information in your report which, if released to your patient, may harm his or her physical or mental well-being, please identify it and briefly state below why you believe it should not be released directly to the patient. Similarly, please specify any other special circumstances which should be taken into account when deciding on the release of your report.

Is there any information in this report which, if released to the patient, might be prejudicial to his/her physical or mental health?

No ☐ *Go to next question*

Yes ☐ Identify the information and state why it should not be released directly to the patient.

Once completed, please return this report directly using the reply paid envelope provided or by post to International Services, Reply Paid 7809, CANBERRA BC ACT 2610.

Continued

10 **Would you like to discuss any aspects of this report with us?**

No ☐

Yes ☐ Int

11 **If someone from Human Services, or another assessor nominated by us, needs to contact you to discuss any aspects of this report, what days/times suit you?**

Day	Time				
	:	am pm	to	:	am pm
	:	am pm	to	:	am pm

12 **Confidentiality of Information**

The personal information that is provided to you for the purpose of this report must be kept confidential under section 202 of the *Social Security (Administration) Act 1999*. It cannot be disclosed to anyone else unless authorised by law. There are penalties for offences against section 202 of the *Social Security (Administration) Act 1999*.

13 **Details of doctor completing this report**

Please print in BLOCK LETTERS or use a stamp.

Name	
Professional qualifications	
Address	Postcode
Phone number	( )
Signature	
Date	/ /
Stamp (if applicable)	

Returning this report

You can give this report and any attachments to your patient or you can return this report directly to us.

However, if you answered 'Yes' at question 9, please make sure to return this report directly to us using the reply paid envelope provided or by post to:

International Services
Reply Paid 7809
CANBERRA BC ACT 2610.

Australian Government
Department of Human Services

centrelink

Work capacity — Customer Information

Who should complete this form?

This form should be completed by a person with a disability, illness or injury who is looking for work and is applying for a Centrelink payment or claiming a pension from another country.

Please return the completed form **within 28 days** of receiving it, to ensure that you get assistance from the earliest date possible.

Privacy and your personal information

Centrelink, Medicare Australia, Child Support and CRS Australia are all part of the Australian Government Department of Human Services. Personal information is protected by law, including the *Privacy Act 1988*. The authority to collect this information is contained in social security law. The information provided on this form will be used to determine your eligibility for payments and suitable services to you and, where relevant, third parties. This information may also be used to detect or prevent fraud and/or recover overpayments.

Your information may also be used by other areas within the Australian Government Department of Human Services, as required or authorised by law. The Australian Government Department of Human Services may give some or all of your information to the Department of Education, Employment and Workplace Relations, Department of Families, Housing, Community Services and Indigenous Affairs and their service providers, and the Department of Health and Ageing. The Australian Government Department of Human Services may disclose limited information about you to other individuals when your circumstances affect their entitlement to payments and services. The Australian Government Department of Human Services can give your information to other persons, bodies or agencies without your permission in circumstances where Commonwealth legislation requires or authorises the disclosure. For example, for the purposes of referral for appropriate assistance.

Where necessary, the Australian Government Department of Human Services or your assessor may contact your doctor(s) and other treating providers to clarify information provided about your medical conditions.

You can get more information from the factsheet titled *Your right to privacy* by going to our website **humanservices.gov.au/privacy** or contact us.

1 Customer details

Customer Centrelink Reference Number (if known) ___ ___ ___

Family name

Maiden name (if applicable)

Previous married name (if applicable)

Other aliases (if applicable)

Given name(s)

Date of birth Day / Month / Year

Male ☐ Female ☐

Address

Postcode

Is there a telephone number we can contact you on? No ☐ Yes ☐ ▶ ( )

Do you need an interpreter? No ☐ Yes ☐ ▶ Preferred language

2 Please list any disabilities, illnesses or injuries that you have

3 When did these disabilities, illnesses or injuries start to make it difficult for you to work or study full-time?

Month / Year

OR I have had my disabilities or illnesses since birth ☐

4 Are you getting any treatment for your disabilities, illnesses or injuries?
e.g. medication, physical therapy, counselling

No ☐
Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

5 Have you ever been hospitalised because of these disabilities, illnesses or injuries?

No ☐
Yes ☐ ▶ Date of last admission — Day / Month / Year

Name of hospital

Duration of stay — From: Day / Month / Year — To: Day / Month / Year

Reason for admission
e.g. operation, investigation, treatment

Number of admissions in the last 5 years

6 Are you expecting to have an operation in the future?

No ☐
Yes ☐ ▶ Type of operation/procedure

Expected date (if known) — Day / Month / Year

Where will operation take place (if known)

Reason for operation

7 **How often does your disability, illness or injury make it difficult for you to:**

	no problem	sometimes	often	all the time	**Please give further details** (if applicable)
sit	☐	☐	☐	☐	
stand	☐	☐	☐	☐	
walk	☐	☐	☐	☐	
climb stairs	☐	☐	☐	☐	
drive a car	☐	☐	☐	☐	
use public transport	☐	☐	☐	☐	
pick up objects	☐	☐	☐	☐	
handle objects	☐	☐	☐	☐	
lift	☐	☐	☐	☐	
carry	☐	☐	☐	☐	
bend	☐	☐	☐	☐	
operate everyday appliances or machinery	☐	☐	☐	☐	
read	☐	☐	☐	☐	
write	☐	☐	☐	☐	
speak	☐	☐	☐	☐	
hear	☐	☐	☐	☐	
concentrate	☐	☐	☐	☐	
remember	☐	☐	☐	☐	
interact with others	☐	☐	☐	☐	
attend work or other appointments	☐	☐	☐	☐	
understand or follow instructions	☐	☐	☐	☐	
sleep	☐	☐	☐	☐	
breathe	☐	☐	☐	☐	
manage your personal affairs	☐	☐	☐	☐	
care for yourself*	☐	☐	☐	☐	
care for others	☐	☐	☐	☐	

* If you have someone caring for you full-time, they may be eligible for a payment for carers. *Please contact International Services if you need further details.*

8 **In a workplace, would your disabilities, illnesses or injuries make it difficult for you to:**

	no	sometimes	often	all the time	**Please give further details** (if applicable)
A **interact with others?**	☐	☐	☐	☐	
B **maintain appropriate behaviour?**	☐	☐	☐	☐	
C **cope with work related stress or pressure?**	☐	☐	☐	☐	
D **learn new tasks?**	☐	☐	☐	☐	
E **remember how to do tasks?**	☐	☐	☐	☐	
F **understand and follow instructions?**	☐	☐	☐	☐	
G **concentrate?**	☐	☐	☐	☐	
H **persist at tasks without unscheduled breaks?**	☐	☐	☐	☐	
I **undertake more than one task?**	☐	☐	☐	☐	
J **look after your personal care needs?**	☐	☐	☐	☐	
K **physically complete tasks?**	☐	☐	☐	☐	
L **move safely around the workplace?**	☐	☐	☐	☐	
M **communicate with others?**	☐	☐	☐	☐	
N **control the use of your language?**	☐	☐	☐	☐	

9 Who is the doctor who you usually see about your disabilities, illnesses or injuries?

e.g. your general practitioner.

Name

Address

Postcode

Telephone ( )

Do you give permission for us to contact this person? No ☐ Yes ☐

10 Have any specialists or other doctors treated you for these disabilities, illnesses or injuries?

No ☐

Yes ☐ ▶ Name

Address

Postcode

Telephone ( )

Date of last visit Day / Month / Year

Conditions for which you were treated

If you have specialist reports, please attach copies.

11 Is there anybody else you have consulted or that has assisted you with any of your disabilities, illnesses or injuries?

e.g.
- counsellor
- social worker
- community health worker
- teacher
- psychologist
- physiotherapist

No ☐

Yes ☐ ▶

1 Name

Profession

Address

Postcode

Telephone ( )

Do you give permission for us to contact this person? No ☐ Yes ☐

2 Name

Profession

Address

Postcode

Telephone ( )

Do you give permission for us to contact this person? No ☐ Yes ☐

If you need more space please attach a separate sheet of paper with details.

12 Is there any other information you feel we need to know about your disabilities, illnesses or injuries?

No ☐

Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

13 School or full-time education details

How old were you when you left school or full-time education? ____ years old

Year of leaving school/education

What grade/year did you reach?

What is the highest educational qualification you obtained? e.g. Year 10 Certificate, Higher School Certificate, Degree

14 Have you gained any other qualifications, skills or experience?

Include things like voluntary work, courses, trade tickets, licences, diplomas, tertiary qualifications.

No ☐

Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

15 Have you ever worked?

No ☐ ▶ Go to **Question 18**

Yes ☐ ▶ What date did you last work? Month / Year

16 What were your last 2 jobs?

Your last job

Type of job

Days worked per week

Was this work: Full-time ☐ Part-time ☐ Casual ☐

Name of employer

Contact phone number ( )

Reason for leaving this job (e.g. retirement, resignation, caring for family, medical condition - specify which medical condition)

Your 2nd last job

Type of job

Days worked per week

Was this work: Full-time ☐ Part-time ☐ Casual ☐

Name of employer

Contact phone number ( )

Reason for leaving this job (e.g. retirement, resignation, caring for family, medical condition - specify which medical condition)

If you need more space please attach a separate sheet of paper with details.

17 Have you been given or offered extra support in the workplace because of your disability, illness or injury, such as modification to your environment, reduced hours of work, alternative duties, retraining etc?

No ☐
Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

18 Have you participated in any programs to help you find work, stay in a job, return to work, manage your injury or help you with vocational rehabilitation, gaining new skills, work experience or training?

No ☐
Yes ☐ ▶

1 Name of provider
Type of program
Dates you participated From (Day / Month / Year) To (Day / Month / Year)

2 Name of provider
Type of program
Dates you participated From (Day / Month / Year) To (Day / Month / Year)

Attach any documentation you have which provides details of your participation in the program, including when the program started and finished, the requirements of the program, what activities you undertook while in the program and for how long.

19 Is there any reason why you could not do a rehabilitation or training program in the future?

No ☐
Yes ☐ ▶ Is this because you are about to have other treatment?
No ☐
Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

Is this drug or alcohol related?
No ☐
Yes ☐

Is there another reason?
No ☐
Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

20 When do you think you will be able to start part-time or full-time work or study?

now ☐ within 6 months ☐ 6–12 months ☐ 12–24 months ☐ more than 2 years ☐ never ☐

21 Did someone help you complete this form?

No ☐

Yes ☐ ▶ Who helped you?

Name

Address

Postcode

Telephone ( )

Do you give permission for us to contact this person? No ☐ Yes ☐

22 Your statement

If the customer cannot sign this form, it should be signed by their legal representative and a copy of their guardianship or power of attorney papers should be attached.

I declare that:

- the information I have given is correct.

I understand that:

- giving false or misleading information is a serious offence.

Your signature

Date

Day / Month / Year

Return this form to:

GPO Box 273
HOBART TAS 7001
AUSTRALIA

1 Check that you have read and signed your statement above.

2 Attach any further information you feel supports your application. If you cannot provide all of the documents immediately, do not delay returning your form. Please supply any remaining documents as soon as possible to Department of Human Services, International Services,
GPO Box 273, Hobart TAS 7001, AUSTRALIA.
NOTE: If you are in New Zealand, lodge this completed form with Work and Income in New Zealand.

ENQUIRIES

If you have any questions please call
(+61 3) 6222 3455 (outside Australia)
131 673 (inside Australia)
Note: Call charges apply - calls from mobile phones may be charged at a higher rate.