



altitude

S U P P O R T E D E M P L O Y M E N T

Work Seeker/Employee - Personal Information

Title: _____ Surname: _____ First name(s): _____

Identity number: _____ Nationality: _____

Sex: Female

Male

Do you have a criminal record?

Yes

No

Physical address: _____ Postal address: _____

Contact numbers: Home _____ E-mail: _____

Work _____

Cell _____

Fax _____

Mode of transport: Private

Public

Independent

Assisted

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SUPPORTED EMPLOYMENT

LANGUAGE	UNDERSTAND	SPEAK	WRITE
English			
Afrikaans			
isiXhosa			
Xitsonga			
Setswana			
isiNdebele			
Sesotho			
Sepedi			
Tshivenda			
Siswati			
isiZulu			
Sign language			

Marital status: Married
 Divorced
 Single
 Widowed

Are you the breadwinner? Yes
 No

Spouse's name: _____ Occupation: _____

Number of dependents: _____

Contact person's name: _____ Tel. no.: _____

(In case of emergency)

Disability Information

Type of disability: (tick all appropriate boxes)

Epilepsy	<input type="checkbox"/>	Psychiatric disability	<input type="checkbox"/>	Learning disability	<input type="checkbox"/>
Hard of hearing	<input type="checkbox"/>	Physical disability	<input type="checkbox"/>	Speech impairment	<input type="checkbox"/>
Deaf	<input type="checkbox"/>	Partially sighted	<input type="checkbox"/>	Other	<input type="checkbox"/>
Intellectual disability	<input type="checkbox"/>	Blind	<input type="checkbox"/>		<input type="checkbox"/>

Assistive devices: (tick all appropriate boxes)

Crutches	<input type="checkbox"/>	Hearing aid	<input type="checkbox"/>
Wheelchair	<input type="checkbox"/>	Visual enlargement	<input type="checkbox"/>
Upper limb prosthetic	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Lower limb prosthetic	<input type="checkbox"/>	None	<input type="checkbox"/>

Do you find any of the following difficult to do?

Walking	<input type="checkbox"/>	Standing (for 5 hours/more)	<input type="checkbox"/>	Using your hands	<input type="checkbox"/>	Planning	<input type="checkbox"/>	Remembering	<input type="checkbox"/>	Writing	<input type="checkbox"/>
Bending	<input type="checkbox"/>	Carrying	<input type="checkbox"/>	Talking	<input type="checkbox"/>	Solving problems	<input type="checkbox"/>	Communicating	<input type="checkbox"/>		<input type="checkbox"/>
Sitting	<input type="checkbox"/>	Lifting (10kg = a pocket of potatoes)	<input type="checkbox"/>	Concentrating	<input type="checkbox"/>	Making decisions	<input type="checkbox"/>	Reading	<input type="checkbox"/>		<input type="checkbox"/>

Please describe your disability and its impact in your own words:



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Do you receive a disability grant? Yes Temporary Permanent
No

Do you use medication? Yes
No

Who referred you? _____ Contact details: _____

DRIVER'S LICENSE

Type of license	Date acquired	Is it valid?	Endorsements/Restrictions

EDUCATION

Highest grade achieved (school): _____ Year: _____ Institution: _____

Subjects:

Post-school training:

Period from	To	Institution	Qualification	Subjects

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Other skills:

Skill	Where acquired	When	How was/is the skill used?
Computer skills			
Management skills			
Administrative skills			
Technical skills			
Supervisory skills			
Other:			

WORK EXPERIENCE

Employer		Position	
Period of service		Wage/Salary	
Contact person		Contact details	
Reason for leaving	End of contract	Retrenchment	Casual
	Dismissal	Resignation	Other

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Which of the following type of jobs may you be interested in? (tick all appropriate boxes)

Cleaning		Administration		Managerial		Professional	
Factory work		Reception/Secretarial					
Warehousing		Office clerk					
Transport industry		Data capturing					
Machine operating						Other:	

Please attach copies of supporting documents to this form

DOCUMENT	YES	NO	N/A	COMMENT
1. Certified copy of ID				
2. Copy of qualifications /training certificates				
3. Criminal clearance certificate				
4. Copy of driver's license				



I hereby authorise you to verify the information I have provided, and I declare that all statements I have made are true.

Signed by applicant: _____ Date: _____

Please mail this completed form to madri@altitudegroup.co.za



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