e-form

Application for Entry of Name in Register for Persons with Disability

1. Name and Surname

2. Address

Telephone No

3. Nationality

4. Age

5. Has there been a previous application? If yes state when

6. Are you NOW, employed or working on your own account?

(a) If so, state occupation and name and address of employer

(b) If not, state (i) previous occupation

period from

to

7. Occupation desired by you

8. Are you in receipt of an Invalidity Pension?

I declare that all the information in this document is true and correct, and that I am applying for my name to be entered in the Register of Persons with Disability. I hereby agree and explicitly consent to have my personal data is collected, held and used by Jobsplus and is exchanged with third parties in order to fulfill the functions required of Jobsplus according to the provisions of the Employment and Training Services Act (Ch. 343 of the Laws of Malta) and Persons with Disability (Employment) Act of 1969.

Jobsplus will use personal data according to the provisions of the Data Protection Act 2018 and General Data Protection Regulations EC/679/2016 and Persons with Disability (Employment) Act of 1969. You should disclose to Jobsplus data which is correct and that should there be any changes, these are communicated to Jobsplus immediately. You have the right to access, change and delete, where applicable, your personal data that Jobsplus holds about you as well as to request that any incorrect personal data is rectified.

Date

Applicant's signature or mark

ID Number

Witness to mark only

Address of witness

ID Number

Medical Certificate*

This information relates to the application for the entry/retention in the Jobsplus Register for Persons with Disability, as per LN 156 of 1995. This Register holds the name of individuals that although fit for employment, require guidance and assistance to engage in employment which is most suitable to their current physical/mental health condition.

Kindly provide hereunder as much detail as possible to facilitate the process.

Name of Applicant	ID Card No

1.

Condition/Disability	Side effects (caused by the condition or the medication taken) to be considered during job search or employment	Is condition progressive?Yes/No

2. **Is the applicant currently fit for employment**

○ Yes ○ No

Medical Officer's signature

Medical Officer's Registration number

Date

Official Stamp
(No applications will be accepted without the stamp)

* Document to be completed by a General Practitioner, however for persons with mental health difficulties, documentation must be completed by a psychiatrist or a psychologist

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