



WANGARANG INDUSTRIES EMPLOYMENT APPLICATION DOCTOR'S REPORT

Wangarang Industries is a supported employment service for people with disabilities. We provide employment across several divisions including:

- *Packaging & Process Work*
- *Cleaning*
- *Gardening & Mowing*
- *Shop/Retail*
- *Sewing & Textiles*

NAME OF APPLICANT:

DATE OF BIRTH:

Disability

What are the applicant's disability/disabilities?

- | | | | |
|-------------------|--------------------------|------------------------|--------------------------|
| Intellectual | <input type="checkbox"/> | Speech/Communication | <input type="checkbox"/> |
| Specific Learning | <input type="checkbox"/> | Psychiatric | <input type="checkbox"/> |
| Autism Spectrum | <input type="checkbox"/> | Neurological | <input type="checkbox"/> |
| Physical | <input type="checkbox"/> | Acquired Brain Injury | <input type="checkbox"/> |
| Vision | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> |
| Hearing | <input type="checkbox"/> | Other (please specify) | <input type="checkbox"/> |
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If more than one, what is the applicant's primary disability?

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Please supply specific information regarding the person's disability and the way it impacts on their functioning.

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If the person suffers from psychiatric illness please specify the type of illness and the treatment.

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Is the person compliant with medication? Yes No

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Is there a treating professional eg psychiatrist, counsellor, case worker with whom the person is in contact? Yes No

Please give details

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Does this person present any challenging behaviours? Yes No

Please give details

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Do they present a danger to themselves or others? Yes No

Please give details

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Does the applicant have any condition that may restrict his/her ability to perform tasks in the workplace?

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Is this disability, illness or injury stable? Yes No

Is this disability, illness or injury being treated? Yes No

If yes, please give details

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Is it an episodic condition? Yes No

Is it a deteriorating condition? Yes No

Does the applicant suffer from pain associated with injury or illness? Yes No
If yes, how is the pain managed?

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Details of current medication (please indicate any affect it may have on the applicants work performance eg. cause drowsiness, limited concentration)

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Health

Does the applicant suffer from any allergic condition? Yes No

If yes, please give details

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Does the applicant suffer from asthma or any other respiratory illness? Yes No

If yes, please give details

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Does the applicant suffer from diabetes? Yes No

If yes, is the diabetes well controlled? Yes No

How is the diabetes treated?

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Is there a diabetic management plan in place? Yes No

If yes, please attach.

Does the person attend the diabetic education centre? Yes No

Does the applicant suffer from seizures? Yes No

If yes, please give details of the type, characteristics and frequency of the seizures.

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Is there a seizure management plan in place? Yes No

If yes, please attach.

Does this person suffer from any infectious disease? Yes No

If yes, please give details

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SUPPORT NEEDS

Would the applicant have difficulty with the following: -

Standing for longer than 2 hours	yes	no
Manual Handling – lifting, carrying, squatting, kneeling	yes	no
Manual dexterity and fine motor skills	yes	no

If yes, please comment

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Communication

Can the applicant communicate clearly? Yes No

Can he/she understand simple spoken English? Yes No

Does the person have any difficulty hearing? Yes No

Please provide details

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Any additional Comments: -

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Doctor’s Name:.....

Address:.....

Phone:.....

Doctor’s Signature:.....

Date:.....