

**Veterans’ Vocational Rehabilitation Scheme (VVRS) Application Form**

**Privacy Notice**

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by DVA for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.

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The information you provide on this form will be used:

* to determine your eligibility for assistance under the Veterans’ Vocational Rehabilitation Scheme (VVRS);
* to make a preliminary assessment of your vocational needs; and
* for statistical purposes.

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| **Personal Details** | | | | |
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| **DVA File Number *(if applicable)\**** | |  | | |
| ***\*Please attach a copy of your Discharge Certificate to this application if you do not have a DVA File Number.*** | | | | |
| **Given Names** |  | | | |
| **Surname** |  | | **Date of Birth** | Click or tap to enter a date. |
|  | | | | |
| **Residential Address** |  | | | |
| **Mobile Number** |  | | **Alternate Number** |  |
| **Email** |  | | | |

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| **Military/Defence Force Service Summary** | | | | | | | | | |
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| **Did you serve in the ADF or British and/or other Allied Forces?** | | | | | | Choose an item. | | | |
| **If you served with British and/or other Allied Forces, what is your length of continuous residency in Australia?** | | | | | | \_\_\_\_\_ years | | | |
| **What branch of Forces did you last serve in?** | | | | | | Choose an item. | | | |
| **Date enlisted** | | Click or tap to enter a date. | | **Date of discharge** | | | | | Click or tap to enter a date. |
| **Service Number** | |  | | **Rank on discharge** | | | | |  |
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| **Principle roles or duties undertaken *(if insufficient space, please attach a separate sheet)*** | | | | | | | | | |
|  | | | | | | | | | |
| **Overseas deployments *(if insufficient space, please attach a separate sheet)*** | | | | | | | | | |
| **Country** | | | **Date from** | | | | **Date to** | | |
|  | | | Click or tap to enter a date. | | | | Click or tap to enter a date. | | |
|  | | | Click or tap to enter a date. | | | | Click or tap to enter a date. | | |
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| **Current Work Details** |

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| **Are you in regular paid work at present?** | Choose an item. |
| **If YES, please provide your employer’s details** | |
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| **Date commenced work for this employer** | Click or tap to enter a date. |
|  | |
| **Please provide a brief description of your tasks in your current job *(if insufficient space, please attach a separate sheet)*** | |
|  | |
| **Average hours worked each week** |  |
|  | |
| **Are there any factors which may affect your future prospects in your current job?** | Choose an item. |
| **If YES, please provide details** | |
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| **Past Employment Details** | | | |
| **Please provide a brief description of your most recent non-military employment** | | | |
| **Employer’s Name** |  | | |
| **Position held** |  | | |
| **Description of tasks** |  | | |
| **Date held from** | Click or tap to enter a date. | **Date held to** | Click or tap to enter a date. |

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| **Employer’s Name** |  | | |
| **Position held** |  | | |
| **Description of tasks** |  | | |
| **Date held from** | Click or tap to enter a date. | **Date held to** | Click or tap to enter a date. |

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| **Employer’s Name** |  | | |
| **Position held** |  | | |
| **Description of tasks** |  | | |
| **Date held from** | Click or tap to enter a date. | **Date held to** | Click or tap to enter a date. |

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| **Details of Injury/Illness That May Affect Your Ability to Work** |

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| **Name of injury or illness** |  |
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| **Have you claimed compensation (from any source)?** | Choose an item. |
| **If YES, has liability been accepted?** | Choose an item. |
| **If liability has been accepted, by whom?** |  |
|  | |
| **Are you currently on a rehabilitation program or required to undertake rehabilitation?** | Choose an item. |
| **Do you intend to claim compensation (from any source)?** | Choose an item. |
| **If YES, from whom?** |  |
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| **Please provide brief details of the medical opinions you have received about how much work or the type of work you can do each week *(if insufficient space, please attach a separate sheet)*** | |
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| **Which of the following pensions or payments do you receive? *(check all that apply)*** | |
| **No pension** | **Disability support pension** |
| **Disability pension** | **MRCS incapacity payment** |
| **Service pension** | **Centrelink Newstart allowance** |
| **Invalidity service pension** | **Special rate disability pension** |
| **MRCS incapacity payment** | **Other** |
| **If OTHER, please specify** |  |

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| **Future Work Goals** |

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| **What do you hope to achieve from participating in the VVRS?** | |
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| **What type of work would you like to do in the future?** | |
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| **How many hours do you hope to work each week?** |  |
|  | |
| **How did you find out about the VVRS?** | Choose an item. |
| **If OTHER, please specify** |  |
|  | |
| **Applicant signature**  ***(please also sign the Authorisation on Page 5)*** |  |

**Please sign and return this completed form and the Authorisation on Page 5 *(with a copy of your Discharge Certificate if you do not have a DVA File Number)* to** [**rehabilitation@dva.gov.au**](mailto:rehabilitation@dva.gov.au) **or mail to:**

**Department of Veterans' Affairs  
GPO Box 9998  
Brisbane QLD 4001**

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| **Authorisation** | | | |
|  |  |  |  |
| **Surname** |  | | |
| **Given Names** |  | | |
| **Residential Address** |  | | |

1. I authorise the Repatriation Commission, the Department of Veterans’ Affairs and its contracted Vocational Rehabilitation Providers to obtain medical or other information needed to process, determine or review this application.
2. I consent to the release of medical, clinical or other information to the Repatriation Commission, the Department of Veterans’ Affairs and its’ contracted Vocational Rehabilitation Providers by any medical practitioner, hospital, clinic, insurance company, the Vietnam Veterans Counselling Service, Centrelink, the Australian Defence Force or other organisation, in relation to this application or its review.

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| **Applicant signature** |  | **Date** | Click or tap to enter a date. |

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| **OFFICE USE** | | | |
|  | | | |
| **Eligible** | Choose an item. | **Date** | Click or tap to enter a date. |
|  | | | |
| **Rehabilitation**  **Delegate Name** |  | | |
| Consultants:  Please assess the veteran named on this form to determine needs for special vocational assistance under the Veterans’ Vocational Rehabilitation Scheme and provide a report to the Rehabilitation Delegate named above.  If you determine that the veteran is not in need of assistance, please advise the veteran of appropriate alternative avenues to explore. | | | |
| **Delegate signature** |  | | |