



FETAC LEVEL 3

Major Award in Employability Skills Vocational Training Programme

Your Contact Details

Name: Male ☐ Female ☐

Address:

Date of Birth:

Telephone No: Email:

In case we cannot contact you – who should we contact?

Name:

Address:

Telephone No: Email:

Personal Details

What is your Personal Public Service Number (PPS No.)?

Are you in receipt of a Social Welfare Payment? Yes ☐ No ☐

If Yes, what type of Social Welfare Payment do you receive?

Training & Education

Junior Cert ☐ Leaving Cert ☐ Rehabilitative Training ☐ FETAC Level 3 ☐ FETAC Level 4 ☐

Name the FETAC Modules that you have PASSED

Where did you go to school?

Did you do a course after School? Where did you do this course?

Work	
Did you ever have a job?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you had a job where did you work?	
More Details	
Do you have a Physical Disability <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Other Disability <input type="checkbox"/>	
Please name your other disability _____	
Can you read and write?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Can you use a computer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Can you travel by yourself on a bus <input type="checkbox"/> DART <input type="checkbox"/> Luas <input type="checkbox"/>	Do you drive? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you take medication?	Yes <input type="checkbox"/> No <input type="checkbox"/>
What medication do you take?	
Are you allergic to anything?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you use a wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you use a walking frame?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a personal assistant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you need help with feeding?	Yes <input type="checkbox"/> No <input type="checkbox"/> Do you need help with toileting? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you live on your own? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Assistive Technology	
Do you use any aids to help you with daily living?	Yes <input type="checkbox"/> No <input type="checkbox"/>
What do you use?	
Is there any other information that we need to know about you?	
The information that I have given you is true	
Signed:	Date:
Please return this form <u>FULLY COMPLETED</u> to:	
The Coordinator, Training & Development Centre, CRC, Vernon Avenue, Clontarf, Dublin 3	