Australian Government

Disability Employment Services

DES Work Assist Employer Form **(Must be completed by the Employer)**

Employer Details: Please note: This form must be completed by the organisation with whom the person seeking DES assistance is employed

Organisation Name:

Employer Address:

Employer Phone Number:

Employer Email Address:

Confirmation of Employment:

Name of Employee:

Details of Employment including date of Commencement:

If Employment has been less than 13 weeks, confirmation that the Employment will last for at least 13 weeks:

The Employee's normal hours of Employment per week:

The Employee's average hours per week of Employment, over a consecutive 13 week period:

The impact the injury, disability or health condition is having on employment, that is, indicating the employee's difficulties carrying out the essential requirements of their job:

The name of the person confirming the details on the Employer Form, their position in the organisation, contact details and signature:

Employer Statement

I, Name confirming details, Position in Organisation with Name of Organisation certify that the information provided above is true and correct. I confirm that Name of Employee is employed by Name of Organisation and I am seeking assistance through DES Provider Name with the aim of enabling this employee to maintain their employment.

Signed: Date:

Contact Phone Number: Contact Email: