employment & labour
Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

Compensation Fund
WORKING FOR YOU

INJURED WORKERS BURSARY APPLICATION FORM 2019/2020

Undergraduate Studies

Workers who cannot return to current work due to injuries or diseases sustained at work and unemployed Compensation Fund pensioners who suffered occupational injuries, as a result, acquired a disablement and other Persons with Disabilities are invited to apply for the bursary to improve their knowledge and skills to return to work or be economically active.

A	DETAILS OF THE STUDY PROGRAMME FOR WHICH YOU WISH TO RECEIVE FUNDING		
Study Programme			
Training Institution			
Student Number/Application Number			
Date of commencement of the study		**Anticipated date of completion**	

B	PARTICULARS OF APPLICANT		
Title		**Surname**	
First names (in full)			
Maiden name (if applicable)		**Date of birth (YYMMDD)**	
Identity number (attach certified copy of ID)			
Nationality	**RSA**	**OTHER**	
	If other, attach certified copies of documents indicating your status. E.g. Permanent Residence, Work Permit, Study Permit, etc.		
Compensation Fund pension number *(only applicable to Injured Workers)*			
Home language		**Male**	**Female**
African	**Coloured**	**Indian**	**White**
Marital status (Circle that which is applicable)	**Married / Widow / Widower Divorced / Judicially separated/ Single/ Other - please specify. _____**	**Do you have a disability?**	Yes / No
Type of disability:	Sight / Hearing / Physcal / Other		
Residential address ***(including postal code)***			
Province	**GP**	**NW**	**LP**	**MP**	**FS**	**KZN**	**EC**	**NC**	**WC**
Local/ District Municipality			
Postal address ***(including postal code)***			
Telephone number during the day (code and number)		Cellphone Number	
E-mail address		Alternative Number	

C	EDUCATONAL INFORMATION						
Indicate the level of secondary school qualification below (X)							
Grade 12		**Grade 11**		**Grade 10**		**Below Grade 10 specify**	

D	EMPLOYER DURING THE PERIOD OF INJURY *(only applicable to Injured Workers)*
Name of Employer	
Field of Work	
Job Description	
Period of Employment	
Date of Injury	
Reason for leaving	
Reference name and Contacts (s)	

E	STATEMENT BY APPLICANT		
"I, the undersigned, declare that the information stated in this form is true and complete, to the best of my knowledge and belief. I have submitted this information knowing that, if I wilfully stated in it anything which I know to be false or which I do not believe to be true, including any omissions, I may be declared ineligible for funding assistance. I voluntarily consent to Compensation Fund and/or its representative/s and/or its contractors and/or sub-contractors processing my personal information (in particular, my financial and education information) as defined in the *Protection of Personal Information Act 4 of 2013* for the purpose/s of assessing my application for funding assistance. I agree that Compensation Fund Entities may have access to my study results and other training related information for monitoring and reporting on my study progress."			
Signature of Applicant		Date	

F	FOR OFFICE USE		
	Verify eligibility		
Vocational Rehabilitation Project Manager/ Coordinator		Date Captured	

Attach the following document:

Certified copy of Identity Document/Smart Card, Copy of your highest school grade or qualification, Proof of residence (not older than more than three months), Acceptance letter from the institution, Study Fee Quotations, Invoice and Certification and verification of disability by a Health Care Professional or Disability Support Office.