SENSITIVE: PERSONAL (when completed)

EMPLOYER SUPPORT PAYMENT SCHEME SUPPORTING INFORMATION FOR SELF-EMPLOYED RESERVISTS

Instructions for Completion.

What the form will be used for

The information on this form will be used by Joint Health Command (JHC) staff to certify certain eligibility requirements for Employer Support Payment Scheme (ESPS) claims made under the CDF Health Approval.

Under the CDF Health Approval, capability employer support payments may be made to eligible medical, dental, nursing or allied health officers who have undertaken eligible periods of Defence service.

The types of service that may be eligible for capability employer support payments are listed in the CDF Health Approval, a copy of which is available on the Defence Reserves Support website at www.defencereservessupport.gov.au.

How the form will be processed

Completed forms can be certified by CJHLTH or SGADFR, or an officer authorised by one of them. Director General Health Business and Plans (DGHBP) has been authorised to undertake this function.

Completed forms should be provided to the DGHBP for certification. If uncertain about any element of the information provided, DGHBP may require that further detail or supporting documentation be provided.

Once the form has been certified by DGHBP, it will be provided to the ESPS staff who will process ESPS claims made under the CDF Health Approval.

Filling in the form

Health Speciality/Discipline – your health speciality/discipline. If you have more than one speciality/discipline, show your predominant civilian occupation.

Name of your business – as per your ABN registration (may be sole trader, partnership, company or trust name – eg A & C Smith or Smith Trust).

Name and location of practice – the name and location of the medical, dental or allied health practice where you work (eg Smithtown Medical Centre, Smithtown, ACT). If you work in multiple locations, specify this.

Employment status – show as business owner, contractor or employee.

- If you are a sole trader in a business, a partner, director or trustee, or have a controlling interest in the business, show your employment status as business owner (unless you provide services as a contractor under a contract for services).

- If you provide your services as a contractor under a contract for services, show your employment status as contractor. You must also detail the business/company that you contract to provide services to.

- If you are employed under a contract of employment, show your employment status as employee. You must also detail the name of the business or practice that you are employed by.

SENSITIVE: PERSONAL

EMPLOYER SUPPORT PAYMENT SCHEME

SUPPORTING INFORMATION FOR SELF-EMPLOYED RESERVISTS

NOTE: Every box must be completed

PMKeyS No	Rank	Initials	Surname

I certify for Financial Year _____

1. Employment Situation (tick box that applies)

☐ I have a bona fide functioning medical, dental or allied health practice
or

☐ I am contracting as a registered health practitioner to a bona fide functioning medical, dental or allied health practice.

2. Health Speciality / Discipline

My predominant medical speciality or discipline is: _____

3. Self-employed Reservist Employment

You must provide details of your self-employment, for which you intend to claim ESPS payments:

Name of your business	**Name & location of practice** (in which you work)	**Your Employment status**	**Average weekly work hours** (in this employment)	**If contractor, name of company you contract to**

Notes:

1. If you undertake more than one activity in your self-employed business, each business activity must be shown.
2. If you are employed under a contract of services, you are a contractor.
3. If you are employed under a contract of employment, you are an employee.

4. Other Employment

Do you have any other employments? Yes / No

If yes, you must provide details of each employment in the following table.

Name of business or practice	**Workplace location**	**Employment status**	**Average weekly work hours (in each employment)**	**If contractor, name of company contracted to**

You are required to complete a new form and provide this to DGHBP if there is any change in your employment circumstances. This should be done within 14 days.

PLEASE NOTE:

- Certification of working hours is subject to paragraphs 35 and 36 of the CDF (Heath) Approval.
- This form cannot be accepted if any boxes are not filled in. You must disclose all your employments and ensure that all information that you provide is accurate.
- Failure to provide accurate information may be considered fraudulent and may result in payment recovery action, imposition of penalties and/or prosecution.
- In completing this form you are responsible for ensuring the information provided is a true reflection of your work arrangements including the hours worked. This declaration may be subject to audit processes from time to time.

Member's signature: _____ Date: _____

For JHC use:

Certified by:

Name: _____

Appointment: _____

Date: _____

Comments: _____