*You can use this form to:*

* **Show cause** *why you should not be excluded, if you have been given a Provisional Exclusion Assessment*
* **Appeal your placement on the List** *if a decision has been made to exclude you and you are placed on the List*
* **Review your placement on the List** *if a minimum period of three years has elapsed since the most recent decision on your matter*
* *Advise of* **Exceptional Circumstances** *to remove your name from the List, if you have been wrongly identified or there is an error in a public record*

**Worker/Person details**

|  |
| --- |
| *Title* |
| [ ]  Mr | [ ]  Ms | [ ]  Mrs | Other |  |
| *First name* |
|  |
| *Surname* |
|  |
| *Date of birth* |
|  |
| *Telephone* |
|  |
| *Email address* |
|  |
| *Street number and name/Postal address* |
|  |
| *Suburb/City* |
|  |
| *State* |
|  |

*Postcode*

|  |
| --- |
|  |

**Employment information**

|  |
| --- |
| *Position with the reporting service provider* |
| [ ]   | Job applicant |
| [ ]  | Former employee |
| [ ]  | Current employee |
| [ ]  | Agency worker |
| [ ]  | Volunteer |
| [ ]  | Student |
| *Date commenced employment* |
|  |
| *Date ceased employment (if applicable)* |
|  |

**Notification details**

|  |
| --- |
| *Notification reference number* |
|  |
| *Review type* |
| [ ]   | **Show cause** – I have received a Provisional Exclusion Assessment advising that my name may be placed on the List |
| [ ]  | **Appeal** – In the last 30 days I have been advised that my name has been placed on the List and I wish to appeal this decision |
| [ ]  | **Review** – At least three years have elapsed since the most recent decision on my matter |
| [ ]  | **Exceptional Circumstances** – I have been wrongly identified or there is an error in a public record, leading to my placement on the List |

**Review details**

|  |
| --- |
| *Have you ever disputed or requested a review of the decision to place your name on the Disability Worker Exclusion List in the past?* |
| [ ]   | Yes |
| [ ]  | No |
| *If ‘Yes’, please provide the date* |
|  |
| *Please outline below why you are requesting a review. (You can attach additional pages if required)* |
|  |

|  |
| --- |
| *Please number any documents/attachments you are providing with your application and list each one below. (You can attach additional pages if required)* |
|  |
| *Signature* |
| ✍ |
| *Date* |
|  |
| **Further information**Please send this form and any supporting documents by email to **DWESU@dhhs.vic.gov.au** or by post to:Disability Worker Exclusion Scheme UnitDepartment of Health and Human ServicesGPO Box 4057MELBOURNE VIC 3001Information regarding the Scheme is available at the [DWES page on the department’s website](https://providers.dhhs.vic.gov.au/disability-worker-exclusion-scheme) <https://providers.dhhs.vic.gov.au/disability-worker-exclusion-scheme>.If you have any further queries, please contact us by email to DWESU@dhhs.vic.gov.au or by phone on (03) 9096 3203. |

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