cetb
Bord Oideachais agus Oiliúna Chorcaí
Cork Education and Training Board

DA 104

APPLICATION FOR RESTORATION OF DISABILITY ALLOWANCE/BLIND PERSONS PENSION FOR PERSONS FINISHING ON FÁS TRAINING PROGRAMMES.

PART 1 : TO BE COMPLETED BY TRAINING PROVIDER

1.Name of Training Provider : _____ **2. Type** : _____ **e.g. FÁS Course Special Needs**.

3. Course Title : _____ **4. Location** : _____ _____**Code:** _____

6. Course Address: _____

7. Telephone No : _____ **8. Fax No** : _____

9. Trainee Start Date : _____ ___ **10: Trainee Finish Date** : _____

11: Training Course Duration : _____ weeks/ months **12 : Hours** Full { } Part –Time { }

We wish to confirm that the above named person has ceased their training on the above course on _____/_____/_____

Signed : _____ Date : _____

Training Provider Stamp

PART 2 : TO BE COMPLETED BY TRAINEE

13. Trainee Name: _____ **4 : PPS No**: _____

15 : Address : _____

16 : Date of Birth : _____ **17 : Phone No** : _____

18 : Claim Number :

PAYMENT METHOD PREFERRED

I wish my social Welfare payment lodged to ( ) Bank Account ( ) Building Society

Bank / Building Society Name : _____ _____ ____ **Name of Account** : _____

Address : _____

Account Type ( ) Deposit ( ) Current A/C **Account No** **Sort Code**

		/			/		

Or I wish to cash my payable orders ( ) at a Post Office

Name of Post Office _____ Address of Post Office _____ _____

Signed : _____ **Date** : _____
Trainee Signature