



Akwesasne Area Management Board

P.O. Box 965

Cornwall, ON K6H 5V1

P) 613-575-2626 F) 613-575-2863

www.aamb.ca

COURSE REGISTRATION FORM

Workshop Name: _____

NAME: _____

CANADIAN MAILING ADDRESS: _____

PHONE #: _____ **ALTERNATE #:** _____ **CELL #:** _____

E-MAIL: _____ **SIN:** _____

DATE OF BIRTH: _____ **SEX:** Male Female

MARITAL STATUS: Married Single Separated Divorced Widowed

BAND MEMBER: Registered MCA MNCC Non-Status Metis Inuit **BAND #:** _____

LANGUAGE: English Mohawk French

DO YOU HAVE A DRIVER'S LICENCE? Yes No

DO YOU HAVE ACCESS TO TRANSPORTATION? Yes No

DO YOU HAVE A DISABILITY? Yes No

DESCRIBE YOUR DISABILITY: _____

INCOME SUPPORT

ARE YOU CURRENTLY EMPLOYED? YES NO

ARE YOU IN RECEIPT OF SOCIAL ASSISTANCE (Welfare)? YES NO

WERE YOU ENTITLED TO RECEIVE E.I. BENEFITS IN CANADA IN THE PAST 3 YEARS? YES NO

IF YES, OFFICE LOCATION: _____

WERE YOU IN RECEIPT OF MATERNITY LEAVE BENEFITS IN THE PAST 5 YEARS? YES NO

ARE YOU CURRENTLY RECEIVING E.I. BENEFITS IN CANADA? YES NO
WEEKLY RATE \$ _____

WORK HISTORY

LAST EMPLOYER: _____

PREVIOUS OCCUPATION: _____

REASON FOR LEAVING: _____

EDUCATION & TRAINING

SECONDARY YEAR ATTAINED: 7 - 8 - 9 - 10 - 11 - 12 - 13

POST SECONDARY YEAR ATTAINED: 1 - 2 - 3 - 4

CERTIFICATE OR DIPLOMA OBTAINED: _____

INDUSTRY CERTIFICATION: _____

Prior to collecting or compiling any personal information, if you are seeking assistance from the Akwesasne Area Management Board (AAMB) or receiving assistance under its programs, you are hereby informed of the purpose for which this personal information is being collected and compiled.

This information is for use by AAMB and Service Canada to:

- determine eligibility to receive services from AAMB;
- assist in verifying eligibility for employment insurance benefits;
- ensure clients who are actively receiving benefits continue to receive them while participating on an AAMB program;
- assess and evaluate AAMB activities;
- to contact other agencies identified below in order to determine possible *cost-sharing partnerships*; and
- to contact individuals to verify information and follow-up.

I, _____, hereby provide my consent as may be required by the AAMB and Service Canada to collect, use and possibly disclose for the purposes as stated above, information to the following agencies:

- **Human Resources Development Canada**
- **Community Support Program (MCA/SRMT)**
- **Economic Development Program (MCA/SRMT)**
- **Akwesasne Mohawk Board of Education (MCA)**
- **Higher Education (SRMT)**

AAMB and Service Canada shall not, in respect of any personal information, use the information for a purpose other than that for which it was provided or disclose the information to any person or body for a purpose other than that for which it is provided except with the consent of the individual to who the information relates, or the written consent of the party that provided the information, or as required by law.

Information which is provided to AAMB and Service Canada is protected under Canada's Privacy Act and you have a right under the Privacy Act to obtain access to this information from AAMB and Service Canada.

Signature

Date

Signature of Witness

Date