

A - CLIENT DATA
Social Insurance Number

Anishinabek Employment and Training Services 212 Camelot Street, Upper Level

Thunder Bay, Ontario P7A 4B1

CLIENT REGISTRATION

PROTECTED WHEN	N COMPLETED			
OFFICIAL USE				
FILE NUMBER:				
OPTION:				
	SOURCE OF			
	FUNDS:			
	1			
	HRDC FILE #:			
Postal Code				
	1			

Last Name			
First Name			
Address			HRDC FILE #:
City / Town	Province	Postal Code	
(Area Code) Telephone Number(s)			
The following information is requested for statistical purposes employment and training programs.	and to determine the effectivene	ss of	
Date of Birth	Sex Male	Female	AGE:
Status Non-Status Metis Are you?	Inuit Non-Aboriginal	Not Declared	YOUTH:
Name of Band	On Reserve	Off Reserve	
Do you consider yourself to be Yes a person with a disability?	Specify	No	
Marital Status?			
Number of dependants?			
Educational Attainment: Highest Grade Completed	?		
What was the occupation of your last job?			PRIOR N.O.C.:
The following questions relate to your partici	pation and source of fund	ing	
What is your start date on this program?			DURATION:
When do you expect to finish this program?			
What is the title of the skill or occupation for which you are being trained			INTERVENTION N.O.C.
Immediately prior to your participation in this progra	am what was your SOURCE	OF INCOME?	C/P:
Social Assistance	Employment Insurance Benefits	Employed	
Self-Employed None	Other		
			P.O.

Under the Privacy Act the personal information collected on this form may be accessed by the participant.

The information is kept on file at the AETS office.

Date	
	Date

B. REQ	UESTED EM	IPLOYMENT (OR TRAI	NING PLEASI	E INDICATE THE I	ENGTH OF TRAINING OR M	MINIMUM SALARY DESIR	RED		
B. REQUESTED EMPLOYMENT OR TRAI		LENGTH OF TRAINING MINIMUM SALARY A								
PLEASE INDIC	CATE YOUR PREFER	RENCE	IF YOU ARE	SEEKING TEMPO	ORARY	Month /	/ Year	Month / Year		
	PERMANENT _	TEMPORARY		IT PLEASE INDIC		.				
				ARE AVAILABLE S, RESPONSIBIL		from	to			
	FULL TIME			,		DAYS EVE	DAYS EVENINGS NIGHTS WEEKENDS SHIFTWORK			
C - QUA	LIFICATION	S								
HIGHEST GRA	ADE/DIPLOMA / DEG	REE	CERTIFICAT	ES		YEAR COMPLETED		PROVINCE		
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DRIVERS LICENSE	□ NO	TO A VEHIC		□ NO	TOOLS	□ NO		EQUIPMENT	□ NO	
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D - WOR	RK HISTORY	RESU	JME ATTA	CHED Y	ES 🗌 NO	RESUM	E WILL FOLLOV	V 🗌 YES	□ NO	
COMPANY NA	AME OF LAST / PRES	SENT EMPLOYER		ADDRESS			TYPE OF BUSINES	S		
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JOB TITLE					•	ANNUALLY \$	FROM			
MAIN DUTIES	/ RESPONSIBILITIES	3								
						REASON FOR LEAV	INC			
						REASON FOR LEAV	ING			
COMPANY NA	AME OF PREVIOUS E	MPLOYER		ADDRESS		TYPE OF BUSINESS				
JOB TITLE				GROSS WAGE	S RECEIVED (C	OMPLETE ONE)	EMPLOYMENT PER	RIOD		
OOD THEE				GROSS WAGES RECEIVED (COMPLETE ONE) HOURLY \$ WEEKLY \$ ANNUALLY \$			FROM TO			
MAIN DUTIES	/ RESPONSIBILITIES	8								
						REASON FOR LEAV	ING			
							-			
		EXPERIENCI	E (INCI	LUDING NON-PAID / VO	OLUNTARY WORK, E	QUIPMENT YOU CAN OPERATE	1			
MAIN DUTIES	/ RESPONSIBILITES	3				DURATION				
							FROM T	·O		
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	ormation on this form may		VACT ACI. Thi	s illioimation may be	released to ensur	e your eligibility under Humar	r Resources Development	Canada and the		
	,	- -								
			S	GNATURE				DATE		

Anishinabek Employment and Training Services

HEAD OFFICE: Ojibways of the Pic River First Nation PO Box 193 Heron Bay, ON POT 1R0



BRANCH OFFICE 212 Camelot Street, Upper Level Thunder Bay, ON P7A 4B1 Phone: (807) 346-0307 Fax: (807) 346-0310

Email: aets@aets.org

CONSENT TO THE RELEASE OF INFORMATION

I,		consent to the release of information
•		ment and Training Services Local Delivery
		es, with respect to my educational, training
Or employme	ent-related activities:	
1.	Human Resources Development Canada	
2.	Union of Ontario Indians	
3.	Training Institution:	
4.	Social Services:	
5.	Other:	
6.	Other:	
performance,	or any other information required by	egards to course duration, attendance, academic the Anishinabek Employment and Training offidential between all parties noted above.
Dated, this	day of	20
SIGNATURE	E	
WITNESS		

Anishinabek Employment and Training Services

Claims only for the purpose of establishing eligibility for El Supports and Measures. For which purpose my personal information has been requested by and may be disclosed to: (Identity & Address of the Body or Person Authorized to Receive and/or Use this information) THIS SECTION COMPLETED BY HRDC ONLY: a) Current BPC c/w Start Date: Benefit Rate: \$ /Week Date of First Week Benefits are Payable or b) Dormant BPC c/w Date of Last Week Benefits Paid (Reachback Client's who have Qualified for El in Past 3 Years) or c) Dormant Maternity/Paternal/Sick BPC c/w Start Date: (Reachback for Special Benefits Recipients Commencing Within the Past 5 Years) Comments If any: (Otate) (Signature of Individual Giving Consent) (Date)		S.I.N.:	
(Name of individual) and/or use of personal information dealing with current & dormant Employment Insurance Claims only for the purpose of establishing eligibility for EI Supports and Measures. For which purpose my personal information has been requested by and may be disclosed to: (Identity & Address of the Body or Person Authorized to Receive and/or Use this information) THIS SECTION COMPLETED BY HRDC ONLY: a) Current BPC c/w Start Date: Benefit Rate: \$ /Week Date of First Week Benefits are Payable or b) Dormant BPC c/w Date of Last Week Benefits Paid (Reachback Client's who have Qualified for EI in Past 3 Years) or c) Dormant Maternity/Paternal/Sick BPC c/w Start Date: (Reachback for Special Benefits Recipients Commencing Within the Past 5 Years) Comments If any: (Signature of Individual Giving Consent)	REQUEST FOR DISCLOSU	JRE OF EI PROGRAM ELI	GIBILITY
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Date of First Week Benefits are Payable	THIS SECTION COMPLETED BY H	RDC ONLY:	
(Signature of Individual Giving Consent) (Address) (Telephone Number) **Note: If the individual wishes to refuse consent he/she should destroy this form.	Date of First Week Benefits are Pa or b) Dormant BPC c/w(Reachback Client's who have Qua or c) Dormant Maternity/Paternal/Sick	ayable Date of Last Week Benefits l lified for EI in Past 3 Years) BPC c/w Start 1	
(Address) (Telephone Number) **Note: If the individual wishes to refuse consent he/she should destroy this form.	` •		5 Years)
(Telephone Number) **Note: If the individual wishes to refuse consent he/she should destroy this form.	(Signature of Individual Giving Consent)		(Date)
**Note: If the individual wishes to refuse consent he/she should destroy this form.	•		
	(Telephone Number)		
Varified by:	**Note: If the individual wishes to refuse conse	ent he/she should destroy this form.	
Verified by: Date: Time:	Verified by:	Date:	Time:

