AKWESASNE AREA MANAGEMENT BOARD
JOB CREATION PARTNERSHIP
ADVANCE PAYMENT CLAIM FORM

FILE NUMBER:	SOURCE DOC.
PERIOD CLAIMED: TO:	SOURCE DOC.
IS THIS YOUR FINAL CLAIM ? YES NO	

NAME OF EMPLOYER:			
MAILING ADDRESS:			
PROVINCE:	POSTAL CODE:	CONTACT PERSON:	PHONE NUMBER:

OTHER COSTS THIS CLAIM	AMOUNT COL 1	LINE OBJECT	VARIANCE COL 2	ADJUSTED AMOUNT COL 3	CUMULATIVE PAID COL 4
TOTAL >		5224			

EMPLOYER CERTIFICATION:

I/WE CERTIFY THE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY/OUR KNOWLEDGE AND CLAIMED IN ACCORDANCE WITH THE AGREEMENT.

AGREEMENT SIGNATORY

[PLEASE PRINT NAME/DATE]

A.A.M.B. / OFFICIAL USE:

TYPE	AMOUNT	CR	CHEQUE INFORMATION	DATA ENTERED

CERTIFIED IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE AGREEMENT:

A.A.M.B SIGNATORY

DATE

OFFICIAL USE ONLY:

ORG. TYPE:	PROJECT OFFICER	NOC CODE:	SIC CODE:	ACTIVITY CODE:	