REGISTRATION FORM WORKSHOP NAME:

***Required fields are shaded**

NAME: **SOCIAL INSURANCE#:**

HOME ADDRESS:

MAILING ADDRESS:
(IF DIFFERENT THAN HOME)

HOME PHONE #: **ALTERNATE:** **CELL:**

E-MAIL:

DATE OF BIRTH: (MM/DD/YY) **SEX:** ○ MALE ○ FEMALE

MARITAL STATUS: ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

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

LANGUAGE: ○ English ○ Mohawk ○ French

NUMBER OF DEPENDENTS: **AGES:**

SOCIAL ASSISTANCE RECIPIENT: ○ Yes ○ No

DO YOU HAVE A DRIVER'S LICENCE? ○ Yes ○ No

Driver's Info: Class ____ Number _____Province/ State: _____ Expiry Date: (MM/DD/YY) _____

DO YOU HAVE ACCESS TO TRANSPORTATION? ○ Yes ○ No

DO YOU HAVE A DISABILITY? ○ Yes ○ No

DESCRIBE YOUR DISABILITY:

EDUCATION INFORMATION

(LIST JUNIOR HIGH /HIGH SCHOOL AND COLLEGE INFORMATION -IF APPLICABLE)

	Grade 7-13, College, Universiy	Diploma, Degree	Name of School	Area of Study	Address	City	Date Completed (MM-DD-YY)
1							
2							
3							

CERTIFICATES

	CERTIFICATE	LEVEL	REGISTRAR	EXPIRY DATE(MM-DD-YY)
1				
2				

EMPLOYMENT HISTORY (If any, fill out below):

NAME OF EMPLOYER:

JOB TITLE: **RATE OF PAY:**

JOB DUTIES:

START DATE: (MM/DD/YY): **END DATE: (MM/DD/YY)**

REASON FOR LEAVING:

NAME OF EMPLOYER:

JOB TITLE: **RATE OF PAY:**

JOB DUTIES:

START DATE: (MM/DD/YY): **END DATE: (MM/DD/YY)**

REASON FOR LEAVING:

CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

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/Iohahi:io(MCA)/ any Educational/Training Institution that a client of AAMB is attending.**
- **Higher Education (SRMT)**
- **Child & Family Services (ACFS/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**