



Akwesasne Career & Employment Support Services

PO BOX 965, Cornwall, Ontario K6H 5V1
Phone: 613-575-2626 | Fax: 613-575-2863
www.acesjobs.ca

THIS FORM MUST BE COMPLETED IN FULL TO BE CONSIDERED

INTERNS & APPRENTICES PROGRAM APPLICATION FORM

File Number:
AP-

REVENUE CANADA BUSINESS #/PAYROLL # (mandatory):
(if none – third party sponsorship letter must be attached)

Employer Name:

Street Address:

City:

Province:

Postal Code:

Phone Number:

Alt. Phone Number:

Fax Number:

Contact Person:

Email Address:

Type of Organization: Profit Non-Profit

IS ORGANIZATION GOVERNED BY A BOARD? YES NO (IF YES, A RESOLUTION AUTHORIZING THIS APPLICATION MUST BE ATTACHED)

STATE THE MAIN PRODUCTS OR SERVICES OF YOUR COMPANY AND HOW LONG YOU HAVE BEEN OPERATING:
(Must be fully operational for 6 months or more in order to be eligible for this program)

PLEASE STATE THE OBJECTIVES, ACTIVITIES, AND EXPECTED RESULTS OF THE PROJECT: (attach a separate page if necessary)

DURATION OF ACTIVITY:

LOCATION OF ACTIVITY:

FROM:

TO:

Insurance Coverage:

WSIB/CSST FOR EMPLOYEES
 YES NO

COMPREHENSIVE GENERAL LIABILITY FOR BUSINESSES
 YES NO

HAVE YOU SUBMITTED AN APPLICATION ELSEWHERE? YES NO

IF YES, PLEASE INDICATE WHERE AND WHO THE CONTACT PERSON IS:

* ACCESS OFFICE USE ONLY *

ORG TYPE:

PROJECT OFFICER:

NOC:

SIC:

ACTIVITY CODE:

FINANCIAL SUMMARY

WAGE COSTS

OCCUPATIONS (1 per line) COL 1	# OF WEEKS COL 2	HOURS PER WEEK COL 3	TOTAL HOURS COL 4	ACCESS RATE PER HOUR (\$16.70) COL 5	EMPLOYER TOP UP PER HOUR COL 6	TOTAL RATE PER HOUR COL 7
TOTALS:				(4X5) 1)		

MERC (EMPLOYER IS RESPONSIBLE FOR MERC ON EMPLOYER TOP UP)

MANDATORY EMPLOYER RELATED COSTS: _____ % X TOTAL WAGES = 2) (EI/4% Vacation Pay/CNESST or WSIB/CPP)

TRAINING COSTS (DETAILS MUST BE PROVIDED ON THE ATTACHED TRAINING PLAN FORM)

Max = \$20/hour x total number of training hours for off-site purchased training only.	TOTAL = 3)

SPECIAL COSTS FOR THE DISABLED

Max = \$10,000 per participant (3 quotes MUST be obtained for Special Costs for the Disabled)	TOTAL = 4)

TOTAL ACCESS PROJECT COST (1-4): 5)

FUNDS FROM OTHER SOURCES AND/OR EMPLOYERS CONTRIBUTION

	TOTAL = 7)

PROJECT GRAND TOTAL = 8)

I/WE CERTIFY THAT EACH JOB REQUESTED IS IN ADDITION TO EMPLOYMENT PLANNED FOR THE PERIOD BEING PROPOSED.

(PRINT NAME)

(TITLE)

(SIGNATURE)

(DATE)

(PRINT NAME)

(TITLE)

(SIGNATURE)

(DATE)



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JOB DESCRIPTION FORM

ACCESS USE ONLY

FILE NUMBER:

PLEASE COMPLETE THE FOLLOWING FORM FOR EACH OCCUPATION BEING REQUESTED:

1) POSITION / OCCUPATION TITLE:		2) DO YOU HAVE A PARTICIPANT IN MIND? <input type="checkbox"/> YES <input type="checkbox"/> NO				
3) HOURS OF WORK / DAYS OF THE WEEK:						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
4) WHAT IS THE PREVAILING WAGE RATE FOR THIS POSITION WITHIN YOUR ORGANIZATION?						
5) WHO IS THE IMMEDIATE SUPERVISOR FOR THIS PERSON? (NAME AND POSITION TITLE)						
6) DUTIES: (PLEASE LIST ALL DUTIES PARTICIPANT IS EXPECTED TO FULFILL)						
7) BASIC QUALIFICATIONS/SKILLS: (WHAT ARE THE MINIMUM ACCEPTABLE ACADEMIC AND/OR SKILL LEVEL REQUIRED FOR THIS POSITION)						
8) KNOWLEDGE & ABILITIES: (REQUIRED TO PERFORM DUTIES)						



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ACCESS USE
FILE #

TRAINING PLAN FORM

TRAINING (Outlined Attached)		Provider	Dates / Total Hours	Cost
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			

How will training / work performance be evaluated:

Qualifications of Trainers (Resumes of Trainers should be attached if not provided by a recognized training institute):