



# Akwesasne Career & Employment Support Services

PO BOX 965, Cornwall, Ontario K6H 5V1  
Phone: 613-575-2626 | Fax: 613-575-2863  
[www.acesjobs.ca](http://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	# OF WEEKS	HOURS PER WEEK	TOTAL HOURS	ACCESS RATE PER HOUR	EMPLOYER TOP UP PER HOUR	TOTAL RATE PER HOUR
(1 per line) COL 1	COL 2	COL 3	COL 4	(14.875 hr.) COL 5	COL 6	COL 7
<b>TOTALS:</b>				(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)
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## 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.	<b>TOTAL =</b> 3)

## SPECIAL COSTS FOR THE DISABLED

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

<b>TOTAL ACCESS PROJECT COST (1-4):</b> 5)
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## FUNDS FROM OTHER SOURCES AND/OR EMPLOYERS CONTRIBUTION

	<b>TOTAL =</b> 7)

<b>PROJECT GRAND TOTAL =</b> 8)
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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):



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## Intern & Apprentices Program - Advance Payment Claim Form

FILE NO.:	SOURCE DOC:
PERIOD CLAIMED: (MM/YYYY) – (MM/YYYY)	SOURCE DOC:

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

PARTICIPANT NAME/OCCUPATION COL 1	HOURS CLAIMED COL 2	ACCESS HOURLY RATE COL 3	TOTAL CLAIMED COL 4	ACCESS USE	ACCUMULATED TO DATE ACCESS USE
				5220 / 5420	
WAGE COST:				5220 / 5420	
MANDATORY EMPLOYER RELATED COSTS:				5223 / 5423	
TRAINING COSTS:	OFF JOB SITE	TOTAL HOURS	RATE PER HOUR		
TRAINING COST:				5226 / 5426	
SPECIAL COSTS FOR THE DISABLED:				5252 / 5452	
TOTAL CLAIM:					

### 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
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### ACCESS / OFFICIAL USE:

TYPE	AMOUNT	CR	CHEQUE INFORMATION	DATA ENTERED

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

ACCESS SIGNATORY	DATE
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### \* ACCESS USE ONLY \*

ORG TYPE:	PROJECT OFFICER:	NOC:	SIC:	ACTIVITY CODE:
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## ACTIVITY REPORT

PLEASE PROVIDE A STATEMENT OF THE ACTIVITIES UNDERTAKEN AND/OR THE TRAINING PROVIDED TO THE PARTICIPANTS (EMPLOYEES) DURING THE PERIOD BEING CLAIMED.