



**APATISHIWIN SKILLS DEVELOPMENT
CREE BURSARY APPLICATION FORM
FOR POST-SECONDARY STUDENTS**

PERSONAL INFORMATION				
Social Insur. Number	Family Name	First Name	Telephone	Cell
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Permanent Address		City/Town	Province	Postal Code
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Mailing Address during Training (if different than above)		Date of Birth	Age	Band Number
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Disabled Person <input type="checkbox"/>	If So, Disability <input type="text"/>	Declared being able to work <input type="checkbox"/>		
Highest Level of Education <input type="text"/>	Email <input type="text"/>			

ASD CONTRACT RELATED INFORMATION (ASD use only)				
ASD File Number	ASD Program	Start Date	End Date	Project Title
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

POST-SECONDARY PROGRAM INFORMATION	
Name of Post-secondary Institution:	_____
Name of Post-secondary or Vocational Program:	_____
Institution Contact Person:	_____ Tel# _____

PARTICIPANT ELIGIBILITY (obligatory)
Proof of enrolment submitted: <input type="checkbox"/> Yes <input type="checkbox"/> No
Post-secondary program or vocational training program leading to an accredited degree/diploma: <input type="checkbox"/> Yes <input type="checkbox"/> No
Full-time student in the chosen program: <input type="checkbox"/> Yes <input type="checkbox"/> No
I have completed at least 30 days in the program: <input type="checkbox"/> Yes <input type="checkbox"/> No

CREE BURSARY PROGRAM CONTRIBUTION: \$500

Direct Deposit Information:
Bank _____ Bank # _____ Transit # _____ Account # _____

I declare that the information I provided above is true. I agree that this information will be used to determine my eligibility for funding and services provided by the ASD and may be shared with the various government funding agencies. Should anything change regarding my personal information or the data provided, I will immediately notify ASD. I acknowledge that ASD will recapture any amounts or benefits to which I was not entitled and that I will be accountable for reimbursing them. Finally, if applicable, I authorize, the CSB to disclose to ASD upon request, the outcome of my training program (i.e. not completed, received an attestation or received a diploma).

Participant's Signature: _____	Date _____
Recommended by ASD Counsellor: _____	Date _____
Verified by the Program Officer: _____	Date _____
Decision by Program Officer: <input type="checkbox"/> Approved <input type="checkbox"/> Rejected	