



Advanced Education, Skills and Labour

**Initial Employee/Client Contact Form**

EMPLOYER/ORGANIZATION: \_\_\_\_\_

AGREEMENT # \_\_\_\_\_

**CONFIDENTIAL**

*Please Note: All fields (unless indicated) are required to assist in determining eligibility for programs and/or to collect baseline information on program participants as part of the accountabilities specified under the federal/provincial labour market transfer agreements.*

Personal Information - Employee		
Employee Name:		
Address (Street or P.O. Box):		Province:
City or Town:		Postal Code:
Tel. #	Cell #	E-mail:
Social Insurance Number		Applied for, or in receipt of Income Support: Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Not Applicable to Canada-NL Job Grant Participants</i>
Date of Birth _____		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>
What is your preferred language of service and correspondence? English <input type="checkbox"/> French <input type="checkbox"/>	Marital Status	
	Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Common Law <input type="checkbox"/>	
Are you legally entitled to work in Canada? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you a Canadian citizen? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you a student? Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Optional Response</i> - Do you perceive yourself as having a disability that causes you significant difficulty accessing training or employment? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you an Indigenous person? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Last or Current Employment (Prior to the position provided as part of Wage Subsidy or Training)		
Employed or Self-employed Yes <input type="checkbox"/> No <input type="checkbox"/> <b>If yes, please provide the following:</b>		
Name of Employer/Business Name _____		
Type of Employment: Casual <input type="checkbox"/> Contractual <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/>		
Job Title _____ Wage Rate \$ _____ per hour # Hours _____ per week		
Applied for, or in receipt of, Employment Insurance (EI) within the past 60 months: Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, type of claim (check one): Compassion Care <input type="checkbox"/> Maternity <input type="checkbox"/> Parental <input type="checkbox"/> Regular <input type="checkbox"/> Sickness <input type="checkbox"/>		
If on an active EI claim ending soon, do you have enough hours/earnings to file a new EI claim? Yes <input type="checkbox"/> No <input type="checkbox"/>		

Information below is used to collect pre-program participant information. This information will be used to help determine program impacts.

**High School Education**

What is the highest education level you completed in high school? \_\_\_\_\_

Date Completed \_\_\_\_\_ Name of High School \_\_\_\_\_

**Post-secondary Education**

Do you have any post-secondary education? Yes  No

**If yes, please specify highest level of post-secondary education (for more than one post-secondary education completed, please include on separate sheet)**

Program Name \_\_\_\_\_ Institution Name \_\_\_\_\_

Status In Progress  Complete  In-complete

Funding Source

Government Funded  Student Loan

Self-Funded  Other  (please specify) \_\_\_\_\_

**Length** \_\_\_ day(s) \_\_\_ week(s) \_\_\_ year(s) Completion year or last year attended \_\_\_\_\_

**Information on the Wage Subsidy Position or New Position (if Receiving Training)**

How did you become aware of this wage subsidy position or training opportunity?

\_\_\_\_\_  
\_\_\_\_\_

Name of Employer/Business Name \_\_\_\_\_

Job Title \_\_\_\_\_ Wage Rate \$ \_\_\_\_\_ per hour # Hours \_\_\_\_\_ per week

Duties \_\_\_\_\_  
\_\_\_\_\_

Are you related to the Employer? Yes  No

If yes specify relationship \_\_\_\_\_

Expected Start Date (DD-MM-YYYY): \_\_\_\_\_ Expected Finish Date (DD-MM-YYYY): \_\_\_\_\_

**JobsNL Wage Subsidy Participants ONLY**

Are you in receipt of a federal or provincial pension, receiving Workplace NL benefits, or another benefit prescribed by the Minister of AESL (e.g., teachers' pension, military pension, CPP disability)?

Yes  No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date: (DD-MM-YYYY)