**SIOUX LOOKOUT AREA ABORIGINAL MANAGEMENT BOARD**

**P.O. Box 56, 80 Front Street, Sioux Lookout, Ontario P8T 1A1, Tel 807-737-4047, Toll free 1-800-563-2183**

INDIGENOUS SKILLS AND EMPLOYMENT TRAINING PROGRAM

 PROGRAM FOR THE DISABLED FORM

In order for the Sioux Lookout Area Aboriginal Management Board to determine your eligibility to participate in the above-noted program, please complete this form to the best of your ability. Providing inaccurate and/or missing information may delay the start date.

|  |  |
| --- | --- |
| File# |  |
| FirstName:  |  | MiddleInitial: |  | LastName: |  |
| Mailing Address:   |   |
|  |
| SIN #: (9 digits) |  | Birth Date:(dd/mm/yyyy) |  |
| Band Name: |  | Band Number(10 Digits): |  |

1. Do you have a long-term disability? Yes [ ]  No [ ]  Unsure [ ]

 Check all that apply

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  | Hearing | [ ]  | Epilepsy |
| [ ]  | Speaking | [ ]  | Fetal Alcohol Effects (FAE) |
| [ ]  | Seeing | [ ]  | Fetal Alcohol Syndrome (FAS) |
| [ ]  | Mobility / Agility | [ ]  | Arthritis / Rheumatoid Arthritis |
| [ ]  | Mental / Psychological | [ ]  | Chronic Heart Condition |
| [ ]  | Attention Disorder | [ ]  | Developmentally Delayed |
| [ ]  | Learning Disabilities |
| [ ]  | Diabetes with complications – Specify:  |  |

|  |  |
| --- | --- |
| 2. What employment barriers (obstacles) do you feel you may have? Please specify:  |  |
|  |
|  |

By signing the declaration, I am verifying the above conditions and barriers relating to my participation in the program is correct and to the best of my knowledge and wish them to be held on confidentiality with the SLAAMB office.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature:  |  |  Date: |  |
| Project Officer |  |  Date: |  |