



Training Assistance Program (TAP) APPLICATION PACKAGE

EMPLOYER PART 1

Completes "Employer Application", Training Assistance Program

TRAINEE PART 2

Completes "Trainee Application", Training Assistance Program

If you have any questions, please contact your regions career development office.





Training Assistance Program (TAP)

PART 1 - EMPLOYER APPLICATION

NOTE: Trainees must be unemployed or underemployed to be eligible to enter into a TAP agreement.

EMPLOYER INFORMATION	N		
Business's Legal Name	CRA Business Numb	er	P.O. Box Number
Community	Territory/Province		Postal Code
Business Telephone	Business Cell		Email Address
Contact Person: Last Name	First Name		Position/Title
Business Type			1
Have you accessed this program before	? ☐ Yes ☐ No If "Yes", what year?	(MM-DD-YYYY)	
TRAINING INFORMATION	V		
Trainee's Name		Trainee Position/Title	
Trainer Position		Trainer's Qualifications	
Trainee Wage/Hour		Hours /Week	
Training Duration Start Date:		Training Duration End Date:	
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		MM DD VVVV

TRAINING PLAN

Use this as the format or as a guideline. Please add any other information that you may find relevant to your training pla	Use this as the format or as a guideling	e. Please add any other information that	t you may find relevant to your training plan
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Learning Objectives:

What skills, abilities and knowledge will the Trainee acquire and be able to demonstrate at the end of the training period?

Training Methodology: (OR ATTACH A SEPARATE TRAINING PLAN)

Describe tasks and how the trainee will be learning in the time period that you have chosen (i.e. week, month, quarter). Divide the training into as many periods as is practical. Add additional pages as necessary.

TRAINING PERIOD	TOPICS	TRAINING METHODS	EVALUATION METHODS

Other Funding	g Sources:	
	encies from which you are receiving funding for this training plan.	
Comments:		
	Signature of Employer	Date (MM-DD-YYYY)
	o.g. a.a.o o. Ep.o, o.	23.5 (22)
	Name of Employer (please print)	-
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Training Assistance Program (TAP)

PART 2 - TRAINEE APPLICATION

PERSONAL	NFORMATIO	ОИ									
Last Name			First Nam	е		Middle Name(s)	Gende	er	= 🗆 (Other
Social Insurance Numb	per		Date of B	irth		Nunavut Healt	th Card Numbe	er			
				(MM-DD-YY)	(Y)						
Family Type:	☐ Children in Ho	ousehold		☐ No Children	in Household	Number of De	pendents:				
Marital Status:	☐ Single	□ Ma	rried	☐ Common La	w						
Language(s) spoken:	☐ English	☐ Fre	nch	☐ Inuktitut	☐ Inuinnaqtun	☐ Other:					
Language(s) written:	☐ English	□ Fre	nch	☐ Inuktitut	☐ Inuinnaqtun	☐ Other:					
Indigenous Identity:	☐ Inuit	☐ Firs	st Nation	☐ Métis	☐ NTI Card Nun	nber:					
Citizenship:	☐ Canadian	□ Per	manent Re	esident	☐ Other (Explain	າ):	1			_	
Visible Minority:	☐ Yes	□ No		☐ Prefer not t	o report						
Immigrant:	☐ Yes	□ No		Immigration ye	ear:		· · · · · · · · · · · · · · · · · · ·				
Do you identify as havi (Examples include but not or coordination difficulties,	limited to: hearing, vi		obility impai	rment, learning disa			nistory, motor skill	ls			
Type of Disability ☐ Agility ☐ Hearing						Learning □ Mo	otor Skills 🗆 🤄	Speaking	J		
☐ Other (persistent ba	arriers)										
CONTACT IN	IFORMATIO	N									
P.O. Box Number			Commu	nity		Territory	/Province				
Postal Code			Email			Telepho (ne (Home)				
Telephone (Cell)			1	ne (Work)			ed method of co				
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All sections are mandatory - Place a dash or line throug	

EI	DUCATION HIS	STORY					
Highe	est level of education co	mpleted?		Place of	Education		
Name	e of Institution			End Date	e: 	(MM-DD-YYYY)	
						(IVIIVI-DD-1111)	
List a	ny training or education	nal programs you have comple	ted.			OTART DATE	ODADIJATION DATE
	PROGRAM	INSTITUTIO	N	LOCATI	ON	START DATE MM - YYYY	GRADUATION DATE MM - YYYY
1							
2							
3							
E	MPLOYMENT I	HISTORY					
Curre	nt Employment Status Employed (Full- Employed (Part	· ·	oyed (Full-time/T oyed (Part-time/F				
Curre	nt Employer (Business	/Organization):			r Telephone Num	ber:	
Emplo	oyer Address:			()			
,	•						
Rece	nt Employment Histor	ry: Please list most recent emp	oloyment first.				
C	COMPANY NAME	JOB TITLE	DUTIE	ES	FULL-TIME/ PART-TIME	REASON FOR LEAVING	PERIOD OF EMPLOYMENT
					☐ FT Perm ☐ FT Temp ☐ PT Perm		From (MM-YYYY)
					☐ PT Temp		To (MM-YYYY)
					☐ FT Perm ☐ FT Temp ☐ PT Perm		From (MM-YYYY)
					☐ PT Temp		To (MM-YYYY)
					☐ FT Perm ☐ FT Temp ☐ PT Perm		From (MM-YYYY)
					☐ PT Temp		To (MM-YYYY)
Are y Reas	ou willing to move for e	mployment?	☐ Yes	□ No			
Are y	ou willing to move for tr	raining?	☐ Yes	□ No			

Reasons:

you currently claiming Employmer	nt Insurance (EI) Benef	fits? □ Ye	es 🗆 No	
E: If you checked "Yes", please ic	lentify benefit type and	I start date:		
J	□ Regular	☐ Parental	☐ Sick	☐ Special
	Start Date:			
		(N	IM-YYYY)	
DRIVER'S LICENSE				
you have a valid driver's license?	☐ Yes	□ No		
What type (class) of license is	s it?			
☐ Class 1: Tracto	r Trailer Rigs		☐ Class 5: Me	edium and small motor vehicles up to 11,000 kg
☐ Class 2: Buses	exceeding 24 passen	gers	☐ Class 6: Mo	otorcycle
☐ Class 3: Single	bodied motor vehicles	s exceeding 11,000	kg 🛚 Class 7: Le	arner's permit
☐ Class 4: Mediu	m and small taxicab/ a	ımbulance		
you have your airbrakes endorsem	nent? Yes	□ No		
CLIENT DECLARATIO	N AND CONSI	ENT TO REL	EASE PERS	ONAL INFORMATION
I,				, hereby declare that:
I,PLEASE PRINT Y	OUR FULL NAME	,	SOCIAL INSURANCE	, hereby declare that:
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I,	OUR FULL NAME ned in my application f or misleading stateme g the termination of my	for assistance is cor ents may result in le benefits and repay	SOCIAL INSURANCE nplete, accurate and gal action, criminal ment of any benefit	NUMBER d true, to the best of my knowledge. nvestigation, prosecution and my ineligibility
I,PLEASE PRINT You 1. The information contain 2. I understand that false to participate, including 3. I shall immediately not	OUR FULL NAME ned in my application f or misleading stateme the termination of my ify the Department of F	for assistance is corents may result in lebenefits and repaysamily Services sho	SOCIAL INSURANCE nplete, accurate and gal action, criminal iment of any benefit	, hereby declare that: NUMBER d true, to the best of my knowledge. nvestigation, prosecution and my ineligibility is I have already received.
I,	OUR FULL NAME ned in my application f or misleading stateme the termination of my ify the Department of F ovided an email addre	for assistance is corents may result in less benefits and repay Family Services shows, this will be the publich I am not entiti	SOCIAL INSURANCE nplete, accurate and gal action, criminal ment of any benefit uld the circumstance orimary means of columnsed.	, hereby declare that: NUMBER d true, to the best of my knowledge. nvestigation, prosecution and my ineligibility is I have already received. es of my eligibility or participation change. mmunication with me regarding my program.
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Witness Signature