



SMITH'S LANDING FIRST NATION EDUCATION DEPARTMENT  
**APPLICATION FOR  
 TRAINING/CERTIFICATION FUNDING**

<b>OFFICE USE ONLY</b>
Date Received – YY/MM/DD

**YOU MUST SUBMIT AN APPLICATION FOR EVERY TRAINING/CERTIFICATION COURSE**

<b>Your application deadline is:</b>	One month prior to the start date
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**1 STUDENT INFORMATION**

Last Name		First Name	
Middle Name(s)		Previous Last Name(s)	
Home Address		City/Town	Prov/Terr
Address at School (if different than above)		City/Town	Postal Code
Home Phone	Work/Cell Phone	Email Address	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth YYYY/MM/DD	Social Insurance Number	Treaty Number <b>477 -</b>
Current Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law <small>(living together for 12 continuous months)</small>	Dependents <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, how many?	
Do you have any outstanding debts with Smith's Landing First Nation? <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span>			
If yes, what is the debt for?		What is the outstanding amount?	
Is this the first time that you are applying for Smith's Landing First Nation Education Funding? <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span>			
<b>Next of Kin Address (Not your spouse/common law or children)</b>			
Last Name		First Name	
Relationship to you		Home Phone	Work/Cell Phone
Mailing Address		Street Address	
Email Address		City/Town	Postal Code

**INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED**

**Please ensure you provide all requested information and documentation**

Should you have questions or need assistance completing this application, please contact Smith's Landing First Nation:  
**Phone:** (867) 872-4950  
**Fax:** (867) 872-5154

**Return By Mail To:**  
 Smith's Landing First Nation  
 Box 1470, Fort Smith, NT X0E 0P0  
**Email:**  
 education@slfn196.com

Office use only:

SLFNED Student ID: \_\_\_\_\_ Application No: \_\_\_\_\_ Forecast No: \_\_\_\_\_ Approval No: \_\_\_\_\_

## 2 TYPE OF ASSISTANCE

Check off what you are applying for

Basic Living Allowance     Travel     Tuition and Fees     Books

## 3 SPOUSE AND DEPENDANT INFORMATION

Provide the following information for your spouse/children (Please include copies of Health Care Cards for the people listed below)

Name		Health Care Number	Social Insurance Number
Date of Birth YYYY/MM/DD	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
Living with me during school? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how many days each month?	
Name		Health Care Number	Social Insurance Number
Date of Birth YYYY/MM/DD	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
Living with me during school? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how many days each month?	
Name		Health Care Number	Social Insurance Number
Date of Birth YYYY/MM/DD	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
Living with me during school? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how many days each month?	
Name		Health Care Number	Social Insurance Number
Date of Birth YYYY/MM/DD	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
Living with me during school? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how many days each month?	

## 4 PREVIOUS INSTITUTIONS AND PROGRAMS

List the programs and institutions that you have previously been enrolled in (beginning with the most recent)

Institution		Program	Location
Start Date YYYY/MM/DD	End Date YYYY/MM/DD	Sponsored By	Successfully Obtained <input type="checkbox"/> License <input type="checkbox"/> Certificate <input type="checkbox"/> Diploma <input type="checkbox"/> Undergraduate <input type="checkbox"/> Masters <input type="checkbox"/> Doctorate
Institution		Program	Location
Start Date YYYY/MM/DD	End Date YYYY/MM/DD	Sponsored By	Successfully Obtained <input type="checkbox"/> License <input type="checkbox"/> Certificate <input type="checkbox"/> Diploma <input type="checkbox"/> Undergraduate <input type="checkbox"/> Masters <input type="checkbox"/> Doctorate
Institution		Program	Location
Start Date YYYY/MM/DD	End Date YYYY/MM/DD	Sponsored By	Successfully Obtained <input type="checkbox"/> License <input type="checkbox"/> Certificate <input type="checkbox"/> Diploma <input type="checkbox"/> Undergraduate <input type="checkbox"/> Masters <input type="checkbox"/> Doctorate

Print your name: \_\_\_\_\_



## 8 APPLICANT DECLARATION AND CONSENT (Must be signed and witnessed)

This information is being collected to determine my initial and continued eligibility for Smith’s Landing First Nation Education Department (SLFNED) Funding and for the general administration and enforcement of this department. All applicants have the right to examine and request correction of his or her records and request a review by Smith’s Landing First Nation Education Department. If you have any questions about the collection of information, contact Smith’s Landing First Nation at (867) 872-4950.

### Part A – Applicant (Mandatory)

1. **I declare that:**
  - a. The information given on this SLFNED Application for Training/Certification Funding and in the documents in support of this application is true.
  - b. I will immediately notify SLFN in writing if my, my spouse’s, or my dependant’s personal information changes.
2. **I agree to:**
  - a. Follow the terms and conditions of any SLFNED Funding documents that I have signed, including the SLFNED Policies and Procedures.
  - b. Use any SLFNED Funding awarded to me towards the cost of my education and return any SLFNED Funding that I am not entitled to.
  - c. Provide information or documents to verify my initial and continued eligibility for SLFNED Funding within 20 days of the request.
3. **I understand that:**
  - a. I may have to immediately return any SLFNED Funding received in prior, current or future years if there were/are changes to my personal information.
  - b. If I make a false or misleading statement, I may be required to immediately repay all SLFNED Funding received and/or be denied future SLFNED Funding. I may also be subject to criminal prosecution.
  - c. If I have an outstanding debt with SLFN, I may be denied SLFNED Funding.
  - d. SLFNED will contact other agencies to verify the information I have provided as part of determining my initial and continued eligibility for SLFNED Funding and to detect fraud. These agencies may include, but are not limited to the following: federal, territorial or municipal governments including driver and vehicle licensing programs, Human Resource Skills Development including Record of Employment and Employment Insurance, Parental and Maternity Benefits, Health and Social Services, housing management bodies, financial institutions, airline and travel agencies, landlords, educational institutions, employers, and child care providers.
4. **I consent to the release of:** personal information to SLFNED by those agencies listed in 3.d. above to verify any personal information provided to determine my initial and continued eligibility for SLFNED Funding. I understand that if I consent to the release of my personal information to third parties, that this consent is valid until I advise SLFNED in writing that I withdraw my consent.

X  _____	YYYY/MM/DD  Date	X  _____	YYYY/MM/DD  Date
Applicant’s Signature (Mandatory)		Witness’s Signature (Mandatory)	

### Part B – Spouse (Mandatory)

5. **As the applicant’s spouse,** I consent to the release of my personal information to SLFNED by the agencies in section 3.d. above, for the purposes of determining the applicant’s eligibility for SLFNED Funding. I understand that I may withdraw this consent as outlined above.

X  _____	YYYY/MM/DD  Date	X  _____	YYYY/MM/DD  Date
Applicant’s Signature (Mandatory)		Witness’s Signature (Mandatory)	

Print your name: \_\_\_\_\_