

## APPLICATION/REFERRAL FORM PROGRAMS/SERVICES

Please enclose any supporting documentation (ie: educational reports/ medical reports etc.) . Failure to include supporting documentation can delay the applicants's admission.

### PERSONAL INFORMATION

Name: \_\_\_\_\_  
(Last) (First) (Middle)  
Address: \_\_\_\_\_ City/Town: \_\_\_\_\_  
Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: (902) \_\_\_\_\_  
D.O.B.: \_\_\_ M \_\_\_ D \_\_\_ YR Marital Status: \_\_\_\_\_  
Dependants: \_\_\_ y \_\_\_ n # \_\_\_\_\_ Ages: \_\_\_\_\_ to \_\_\_\_\_  
S.I.N.: \_\_\_ / \_\_\_ / \_\_\_ Hospital Card #: \_\_\_ / \_\_\_ / \_\_\_  
Emergency Contact: \_\_\_\_\_ Phone Number: (902) \_\_\_\_\_

### REFERRAL SOURCE (if applicable)

Agency : \_\_\_\_\_  
Name: \_\_\_\_\_ Position/Relationship: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Phone: (902) \_\_\_\_\_ Fax:(902) \_\_\_\_\_ Email Address \_\_\_\_\_

### FINANCIAL INFORMATION

Family Benefits:\$ \_\_\_\_\_/mth Disability Benefits:\$ \_\_\_\_\_/mth  
W.C.Benefits: \$ \_\_\_\_\_/mth Other:\$ \_\_\_\_\_/mth(Specify) \_\_\_\_\_  
Have you received EI in the past 3 years, or 5 years if on a Maternity Claim? \_\_\_ y \_\_\_ n

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## EDUCATION HISTORY

Last Grade Completed: \_\_\_\_\_ Year: \_\_\_\_\_

Type of Program: \_\_\_\_\_ Name of School \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Name of any other Academic Program Attended: \_\_\_\_\_

Dates Program was Attended: From: \_\_\_\_\_ To: \_\_\_\_\_

Other Training: (including on-the-job) \_\_\_\_\_

Name of Training Facility: \_\_\_\_\_

Dates Attended: From: \_\_\_\_\_ To: \_\_\_\_\_

Outcome: \_\_\_\_\_

Other Training: (including on the job) \_\_\_\_\_

Name of Training Facility: \_\_\_\_\_

Dates Attended: From: \_\_\_\_\_ To: \_\_\_\_\_

Outcome: \_\_\_\_\_

Do you or are you suspected of having a learning disability?  Y  N

If yes provide details: \_\_\_\_\_

\_\_\_\_\_

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## EMPLOYMENT HISTORY

Employment/Work Experience History:

1. Employer: \_\_\_\_\_

Position: \_\_\_\_\_

Job Description: \_\_\_\_\_

From: \_\_\_\_\_ to \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

2. Employer: \_\_\_\_\_  
Position: \_\_\_\_\_  
Job Description: \_\_\_\_\_

From: \_\_\_\_\_ to \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

3. Employer: \_\_\_\_\_  
Position: \_\_\_\_\_  
Job Description: \_\_\_\_\_

From: \_\_\_\_\_ to \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

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**PHYSICAL HISTORY**

Please check all that apply:

Physical disability	___	Vision	___
Speech Impairment	___	Hearing	___
Intellectual Disability	___	Other (specify)	_____

Please explain the above checked areas and any other physical conditions that may limit your ability to work (ie: Back, Carpel Tunnel etc): \_\_\_\_\_

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

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently on any Medications:    Y    N

Please list: \_\_\_\_\_  
\_\_\_\_\_

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**MENTAL HEALTH HISTORY**

Long Term/Ongoing \_\_\_ Past \_\_\_ Present \_\_\_

Please explain: \_\_\_\_\_

Psychiatrist/Psychologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Counselor/Social Worker: \_\_\_\_\_ Phone: \_\_\_\_\_

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**ADDICTIONS**

Have you ever had problems with:

Gambling \_\_\_ Drugs \_\_\_ Alcohol \_\_\_

Are you currently receiving treatment? \_\_\_y\_\_\_n

If yes, please describe \_\_\_\_\_

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**LEGAL HISTORY**

CURRENT: Charges Pending \_\_\_ On Parole \_\_\_ On Probation \_\_\_

Please explain: \_\_\_\_\_

\_\_\_\_\_

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**SUPPORT STRUCTURES**

Living Accommodations: \_\_\_\_\_

Childcare: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ N/A

Transportation: \_\_\_\_\_

Family Support: \_\_\_\_\_

Other persons/organizations who provide support: \_\_\_\_\_

\_\_\_\_\_