



GRADUATE MENTORSHIP PROGRAM

Individual Eligibility Form

Application Received By
SkillsPEI

Office Use Only

- Eligible
 Not Eligible

A - POSITION

Please complete the following information regarding the position in which you are applying:

Employer:

Position:

B - PERSONAL INFORMATION

Personal information on this form is collected under section 31(c) of the *Freedom of Information and Protection of Privacy Act* R.S.P.E.I 1988 Cap. F-15.01, as it relates directly to and is necessary for provisions of the Graduate Mentorship Program. The information collected on this application shall be used for eligibility and evaluation purposes. If you have any questions about this collection of personal information, you may contact the manager at your nearest SkillsPEI office, or call 1-877-491-4766.

SOCIAL INSURANCE NUMBER		FILE NUMBER (Office Use Only)
SURNAME	GIVEN NAME	MIDDLE NAME
ADDRESS		
CITY/COMMUNITY	PROVINCE	POSTAL CODE
TELEPHONE NUMBER	OTHER CONTACT NUMBER	EMAIL ADDRESS
DATE OF BIRTH (YYYY/MM/DD)	GENDER Male <input type="checkbox"/> Female <input type="checkbox"/>	
PREFERRED LANGUAGE OF SERVICE English <input type="checkbox"/> French <input type="checkbox"/>		PREFERRED LANGUAGE OF CORRESPONDENCE English <input type="checkbox"/> French <input type="checkbox"/>
Are a Canadian Citizen? Yes <input type="checkbox"/> No <input type="checkbox"/>		Permanent Resident? Yes <input type="checkbox"/> No <input type="checkbox"/>

C - EDUCATION

Field of Study:

Educational Institution:

Date of Graduation:

Level of Education (Check all that apply)

Certificate Diploma Bachelors Degree Master's Degree Phd



D - ELIGIBILITY	
Have you applied for or are you currently in receipt of Employment Insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you had an Employment Insurance claim that ended in the past 36 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you had an Employment Insurance claim (maternity or parental) that began within the last 60 months for which the benefits were paid and are you re-entering the workforce after having left it to care for a newborn or adopted child(ren)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you currently employed? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, how many hours per week are you employed? _____	

E - DECLARATION
<p>I declare that:</p> <p>a) I have read and understood the information provided in the form;</p> <p>b) the information that I have provided to the Department of Innovation and Advanced Learning & SkillsPEI in this form and supporting documentation is true, accurate and complete in every respect;</p> <p>c) if the information described above is false or misleading, I may be required to repay some or all of the financial assistance that may be approved by the Department of Innovation and Advanced Learning & SkillsPEI.</p> <p>I agree that:</p> <p>a) any information I have provided in this form can be subject to a proof of evidence request at any time during the participation in the program.</p> <p>b) the information I have provided in this form shall be shared with departmental officials to contact me regarding program and services administered by the department.</p> <p><input type="checkbox"/> Check (v) if you would prefer that your information not be shared with Department officials to contact you regarding program and services administered by the department.</p>

APPLICANT NAME (PRINT)	SIGNATURE	DATE (YYYY/MM/DD)

OFFICIAL USE ONLY (ELIGIBILITY VERIFICATION)	
DATE	SIGNATURE