Course: _____

Date: _____

SKILLED TRADES UNION EDUCATION PROGRAM
LOST TIME WAGE VERIFICATION FORM

R.R.#1, Port Elgin, Ontario NOH 2C5
Phone: 519-389-3215 / 1-800-265-3735 Fax: 519-389-3845

PLEASE PRINT CLEARLY

SIN: (For Payroll/Expenses)_____ **LOCAL** :_____ **UNIT:** _____

Given Name: _____ **UNIT/COMPANY NAME**: _____

Preferred Name:_____ **Phone (Res.): (_____)**_____

Last Name: _____ **Phone (Cell): (_____)**_____

Address: _____ **Date of Birth (mm/dd/yyyy):** _____

Clock #_____ **Dept.** _____

City: _____ **Gender:** *Please circle* **Male** **Female**

Province: _____ **Emergency Contact**: _____

Postal Code: _____ **Phone:** _____

Email address:_____

Smoker: *Please circle* **Yes** **No** **Roommate Request**: _____

IF ON SALARY CONTINUATION DO NOT COMPLETE (If you continue to receive salary directly from employer)

Current Lost Time Rate: $_____ (AS OF (Date) _____ + COLA: $_____ = Total Hourly Rate: $_____

Expected Rate Change: (when) _____ How Much: $_____

Hours/Pay Period: _____ Aft. Shift Rate: $_____ Night Shift Rate: $_____

Skilled Trades? *Please circle* **Yes** **No** Vacation Pay Percent (if applicable):_____%
Only required if any Loss of Vacation While Attending the Program

Changes in hourly rate will not be made without verification from pay stub or Local Union. We encourage direct deposit to avoid postal delay - Please attach a void cheque.

Applicant Signature: _____ **Date Completed**: _____

Local Union Verification: _____ (signature)

_____ (print name)

_____ (Title: President, Financial Secretary or Chairperson)

SKILLED TRADES UNION EDUCATION ROOMING REQUEST

Due to space limitations in Port Elgin you will be sharing your room. If you have a preferred rooming partner, please fill out the following form or a rooming partner will be automatically assigned for your stay.

Course Date: _____

Participant's Name: _____

Local: _____

Rooming Partner: _____

Thank you for your attention to this matter please return this form with your wage verification form.

PLEASE E-MAIL TO madison.yourth@unifor.org IN ADVANCE OF COURSE DATES

UNIFOR SKILLED TRADES
UNION EDUCATION
CHILD CARE SUBSIDY FORM

Student Name: _____

Local: _____ Unit/Company: _____

Course & Date: _____

****Note** We only provide Financial Assistance for Additional Expenses over and above what you normally pay for child care during the week.**

Name of Child	Birth Date
_____	_____
_____	_____
_____	_____
_____	_____

Educational Programs

a) Normal daily child care expense $_____

b) Additional daily child care expense $_____

Reason for Claim: _____

Student Signature: _____

WE HEREBY AUTHORIZE CHILD CARE SUBSIDY TO BE PAID ON BEHALF OF THE ABOVE STUDENT.

Local Union Verification: _____

Print Name & Title – President, Financial Secretary, Chairperson

Date: _____ _____

Signature of President, Financial Secretary, Chairperson

PLEASE EMAIL TO Madison.Yourth@unifor.org or FAX IN ADVANCE OF COURSE DATES TO: (519)389-3845

Attention: Madison Yourth