

CONSENT TO DISCLOSE AND VERIFY INFORMATION

1 I, _____ consent to the release of information to an authorized
Student name
representative of the Chippewas of the Thames First Nation Post Secondary Office for the purpose of determining or verifying my initial or ongoing eligibility for Post Secondary Educational Assistance and to the collection of information about me, my spouse/partner, my dependents, and/or any children in my care, for these purposes if necessary, and

2 I further consent to the exchange of information between _____
College/University
regarding any information of funds received, attendance, academic progress reports, financial and/or requests for transcripts pertaining to the period as identified, to the Chippewas of the Thames Post Secondary representative:

Start Date: _____

End Date: _____

3 I further consent to the exchange of information with any service provider offering assistance within the mandate of the Chippewas of the Thames First Nation pertaining to paragraph 1 to verify my eligibility for educational assistance.

Student Signature

Date

Witness:

Date:



CHIPPEWAS OF THE THAMES FIRST NATION APPLICATION FOR EDUCATIONAL ASSISTANCE

New Student : File #

Applicants Name:		Telephone #:	Date of Application:	
Street Address:		Cell #:	Date of Birth:	
City, Prov. Postal Code		Residence:	Canadian Residence:	
		On-Rez <input type="checkbox"/> Off-Rez <input type="checkbox"/> U.S. <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Marital Status: S M D C W SEP		# of children (resides w/you)	Band or Registry #: 1660	Bill C-31: Yes <input type="checkbox"/> No <input type="checkbox"/>
Sex of Applicant: Male <input type="checkbox"/> Female <input type="checkbox"/>		E-Mail Address:		
		Must be your child and registered.		

STUDENT EDUCATIONAL PLAN

New <input type="checkbox"/> Re-enrol <input type="checkbox"/> Continuing <input type="checkbox"/>	Allowance Category	PRIORITY
Program / Course applying for:	Institution:	CC <input type="checkbox"/> MA <input type="checkbox"/>
Full <input type="checkbox"/> Part Time <input type="checkbox"/>	Address:	Univ. <input type="checkbox"/> Ph.D <input type="checkbox"/>
Length of Program: 1 2 3 4	City, Prov./State Postal	BA <input type="checkbox"/> Priv. <input type="checkbox"/>
Year of Study: 1 2 3 4	Telephone: Fax:	
	Expected Date of Graduation: Year: Mo: Day:	Dates Applied For (current year only): Start: Yr. Mo. D End: Yr. Mo. D

Student, please estimate your costs:

Current Year

Tuition:	
Books:	
Allowance:	
TOTALS	

Other Expenses: Please List

Please be advised that only "required" other costs will be covered. Must be documented.

Seasonal Travel	
Other	
TOTAL Estimated Costs.	

I confirm by my signature below that the information provided here is accurate and true.

Student Signature

Date

OFFICE USE ONLY:

CATEGORY P1 <input type="checkbox"/> P2 <input type="checkbox"/> P3 <input type="checkbox"/> P4 <input type="checkbox"/>	INSTITUTIONAL ACCEPTANCE FINAL <input type="checkbox"/> CONTINUED <input type="checkbox"/> CONDITIONAL <input type="checkbox"/>
PREVIOUS STUDENT MONTHS: UCEP <input type="checkbox"/> LEVEL 1 <input type="checkbox"/> LEVEL 2 <input type="checkbox"/> LEVEL 3 <input type="checkbox"/>	OCCUPATIONAL CODE: <input type="text"/>