DZ Driver's Training Program

Open your pathway to your first job or a new career.

Anishinabek Employment and Training Services through *Transport Training Centres of Canada*, is pleased to offer up level DZ Ontario Driver's Licence testing and training supports.

Our vision is to lead in the development of a skilled Aboriginal workforce, empowering the Anishinabek, respectful of our culture and heritage.

Accepting Applications Now!

Please see aets.org/DZTraining for application deadlines

Please send all applications to:
Bonnie Cordone, SPF Regional Western Officer
bonnie.cordone@aets.org

Transport Training™ Centres of Canada
DRIVER SAFETY AND TRADE SKILL DEVELOPMENT

AETS
Anishinabek Employment and Training Services

► Training Includes:

- 3 weeks Training – 1 week in Class (or Virtual) and 2 weeks in person.
- Location: Thunder Bay or Sault Ste. Marie – depending on where applicant is from.
- Training Dates: To be confirmed once applications received - Starting early January.

► Admission Requirements:

- 19 years of age.
- A valid "G" class Driver's License (or higher).
- Grade 10 Education: If you do not have grade 10 English or Canadian equivalency we can arrange for you to write the grade 10 equivalence test (multiple choice) here at our office (no charge).
- A completed Ministry of Transportation Medical Report. Once the original is dropped off at the DriveTest Centre and "cleared" they will give you a photocopy that you will need before you register for training. This form must be completed by a doctor or nurse practitioner.
- Drivers Abstract This is a 3-year uncertified driver record search. It's available through the Ministry of Transportation for $12. You will need this before you begin your training with us.
- Personal Protective Gear (AETS will provide if needed)
  - Safety Boots
  - Break away reflective vest
  - Work gloves

Your path. Our ways.

EDUCATION ► TRAINING ► EMPLOYMENT

Tel: (807) 346-0307 Toll Free: 1-866-870-AETS www.aets.org

Mino Bimaadiziwin
Application Checklist (DZ Licence)

Application Deadline: #_____

Your complete application **must** include the:

- ☐ Client Registration Form
- ☐ Consent to Release Information
- ☐ Request for Disclosure of EI Eligibility
- ☐ Photocopy of Status Card (Front & Back)

And

Requirements per Transport Training Centres of Canada

- ☐ Valid "G" class licence
- ☐ Education- Grade 10 or Equivalency
- ☐ MTO Medical Report
- ☐ 3 years uncertified Drivers Abstract
- ☐ 19 years of age

Citizens (on and off-reserve) of these communities may contact:

Applications sent to:
Bonnie Cordone,
Western Regional Officer
Phone: 1-807-346-0307 ext 207
Email: bonnie.cordone@aets.org

☐ Animbiigoo Zaagi'igan Anishinaabek, ☐ Biinjitiwaabik Zaaging Anishinaabek, ☐ Bingwi Neyaashi Anishinaabek, ☐ KiashkiZaaging Anishinaabek, ☐ Red Rock Indian Band	☐ Biigtigong Nishnaabeg, ☐ Michipicoten First Nation, ☐ Pays Plat First Nation, ☐ Pic Mobert First Nation

AETS
Anishinabek Employment and Training Services

PROTECTED WHEN COMPLETED

285 Red River Road
Thunder Bay, ON
P7B 1A9

CLIENT INFORMATION

Social Insurance Number			**Date of Birth** (dd/mm/yyyy)
Last Name	**Middle Initial**		**First Name**
Mailing Address			**Postal Code**
City/Town	**Province**	**Home Phone**	
Email		**Cell Phone**	

Indigenous Group ☐ Registered Indian ☐ Metis ☐ Non-status Indian ☐ Inuit

Gender ☐ Male ☐ Female ☐ Unspecified

Marital Status ☐ Married or equivalent ☐ Seperated ☐ Single ☐ Divorced ☐ Widowed

Number of dependent children *(living with you)*

Name of Band

Is child care needed? ☐ yes ☐ No

Living on Reserve ☐ Yes ☐ No

Do you consider your self to be a person with a disibility ☐ Yes ☐ No

Languages Spoken ☐ English ☐ French ☐ Ojibway ☐ Other:

Employed Status *at intake* ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Student

NOC CODE:

Education Level *at intake*

☐ No formal education
☐ Up to Grade 7-8
☐ Grade 9-10
☐ Grade 11 or 12 incomplete
☐ University - Bachelor Degree
☐ Some Post-Secondary
☐ Secondary School Diploma/GED
☐ Apprenticeship/Trades certificate or diploma
☐ College, CEGEP, or other non-university certificate or diploma
☐ University certificate or diploma
☐ University - Masters
☐ University - Doctorate

Trades (Including Heavy Equipment)	Level/Red Seal	Specialization	Years Experience
1			
2			

CERTIFICATES (First Aid/WHMIS/Fall Arrest/Chainsaw/Customer Service/Food Safety)

Certification	level	Registrar	Expiry date
1			
2			

Are you ready, willing and available for work/training? ☐ Yes ☐ No

If yes, what type of employment? ☐ Full Time ☐ Part time ☐ Seasonal ☐ Self-employed ☐ Contract

Are you willing to relocate? ☐ Yes ☐ No

Working shiftwork? ☐ Yes ☐ No

Hourly wage expecation? ☐ Min-Wage ☐ min wage - $20 ☐ Over 20$

Clean criminal record ☐ Yes ☐ No ☐ Not Sure

Vaild passport? ☐ Yes, Expiry Date _____ ☐ No

Volunteer work

Computer/Technology Skills:

☐ Microsoft Word ☐ Microsoft Excel ☐ Powerpoint ☐ Email/Internet Search

☐ Office Phone Systems ☐ GIS ☐ Other: _____

Physical Capabilities:

☐ Sitting ☐ Standing ☐ Lift Over 50 lbs ☐ Walking ☐ Outdoor Work

Licences (Class)	Number	Province	Expiry date
1			
2			

TRADITIONAL/CULTURAL SKILLS (Trapping, Hunting, Fishing, Beading, Painting, Carving, Woodworking)

EMPLOYMENT HISTORY starting from most recent work experience, please list employment history:

Employer	Job Title	Dates	Reason for leaving
1			
2			
3			

SOURCE OF INCOME *at intake*

Employment ☐ Yes ☐ No

Ontario Works Recipient ☐ Yes ☐ No

Employment Insurance (EI) Benefits ☐ Yes ☐ No

☐ Reach-Back Client (on EI in the last 3 years or on Special Benefits in the last 5 years)

☐ None ☐ Other _____

Barriers to Employment - Check all that apply

☐ None ☐ Education ☐ Other _____

☐ Remoteness ☐ Lack of Work Experience ☐ Physical Emotional or Mental Health

☐ Language ☐ Lack of Work Transportation ☐ Lack of Labout Force Attachment

☐ Economic ☐ Lack of Marketable Skills ☐ Dependant Care

Action Plan Start Date *today's date* (dd/mm/yyyy) :

Under the Privacy Act the personal information collected on this form may be accessed by the participant.

The information is kept on file at the AETS office.

Signature of Participant:	**Date**

AETS
Anishinabek Employment and Training Services

HEAD OFFICE:
Biigtigong Nishnaabeg
73 Pic River Road
P.O. Box 193
Pic River, ON
P0T 1R0

BRANCH OFFICE:
(Mailing Address)
285 Red River Road
Lower Level
Thunder Bay, ON
P7B 1A9

Tel: (807) 346-0307
Fax: (807) 346-0310
Email: aets@aets.org

CONSENT TO THE RELEASE OF INFORMATION

As sponsoring agent, Anishinabek Employment and Training Services (AETS) may require the exchange of information in regard to intervention duration, attendance, academic performance, or the exchange of support information with trainers or other community partners.

I, _____ consent to the release of information between any representative of the Anishinabek Employment and Training Services and representatives of the following agencies, with respect to my educational, training or employment-related activities:

- First Nation Community: _____
- Ontario Works: Yes ☐ No ☐
- Employment and Social Development Canada: Yes ☐ No ☐
- Training Institution: _____
- Photo/image Release-I grant AETS the right to photograph, record, and use the product of these images or recordings of me for AETS promotional purposes. I am over 18 years of age: Yes ☐ No ☐
- I consent to the disclosure and use of my personal information dealing with current or dormant Employment Insurance (EI) claims, for the purpose of establishing EI eligibility for EI supports and measures: Yes ☐ No☐

AETS will hold your information confidential between parties noted above, except in the following circumstances:

- If you give us permission to share information with others who can assist you
- We believe that you present a risk of harming yourself, or others (we are obligated to respond)
- We are required by law to release information

Date : _____

Print Name : _____

Signature : _____

Witness : _____

AETS
Anishinabek Employment and Training Services

HEAD OFFICE:
Biigtigong Nishnaabeg
73 Pic River Road
P.O. Box 193
Pic River, ON
P0T 1R0

BRANCH OFFICE:
(Mailing Address)
285 Red River Road
Lower Level
Thunder Bay, ON
P7B 1A9
Tel: (807) 346-0307
Fax: (807) 346-0310
Email: aets@aets.org

S.I.N: _____

REQUEST FOR DISCLOSURE OF EI PROGRAM ELIGIBILITY

I, _____ do hereby consent to the disclosure of
(Name of individual)

and/or use of personal information dealing with current & dormant Employment Insurance

Claims only for the purpose of establishing eligibility for EI Supports and Measures.

For which purpose my personal information has been requested by and may be disclosed to:
Anishinabek Employment & Training Services, 285 Red River Road, Thunder Bay, Ontario P7B 1A9
(Identity & Address of the Body or Person Authorized to Receive and/or use this information)

THIS SECTION COMPLETED BY HRDC ONLY:

a) Current BPC c/w _____ Start Date: _____
Anticipated Expiry Date: _____ Benefit Rate: $ _____/Week
Date of First Week Benefits are Payable _____
Or

b) Dormant BPC c/w _____ Date of Last Week Benefits Paid _____
(Reachback Client's who have Qualified for EI in Past 3 Years)
or

c) Dormant Maternity/Paternal /Sick PBC c/w _____ Start Date: _____
(Reachback for Special Benefits Recipients Commencing Within the Past 5 Years)

Comments, if any:_____

_____ _____
SIGNATURE of Individual Giving Consent Date

_____

_____
Address

_____
Telephone Number

Verified by: _____ Date: _____

Transport Training™ Centres of Canada Inc.
DRIVER SAFETY AND TRADE SKILL DEVELOPMENT

Pre-Enrolment Application

Please complete and return to the school as soon as possible.

General Information

Last Name:	First Name (Full):		M_____ F_____
Address:	City:		Postal Code:
Cell Phone: ( )	Birth Date: YY - MM - DD		
Home Phone: ( )	Email Address:		
License No:	Province:	Class:	Expiry:

Please indicate your training preference(s): _____ AZ _____ HEO _____ Other

If **Other**, please specify: _____

When are you hoping to begin training? _____ Month _____ Year

Source(s) of Funding: _____

Education

Grade Completed: _____ School: _____

College/University: _____ City/Province: _____

Course(s) taken: _____ Graduating Year: _____

Medical Information

Do you have any physical problems that you would like us to considering in your training? _____ Yes ____ No

If **Yes**, please provide details: _____

Do you require glasses? _____ Yes _____ No If **Yes**, when? _____

Name of Family Doctor: _____ Telephone Number: _____

Address: _____

For students who are interested in AZ Training

How long have you had a driver's license? _____ Years

Has your license been suspended in the past three (3) years? _____ Yes _____ No

If **Yes**, why? _____

Have you been involved in an accident in the past three (3) years? _____ Yes _____ No

If **Yes**, why? _____

Applicant Declaration

The information set forth in this application is true and complete.

_____ _____

Applicant Signature Date

2565 Kingsway Blvd. Sudbury, ON P3B 2G1 | Phone: (705) 521-1157 | Fax: (705) 521-1156

Medical Report / Rapport médical

Ontario

Tel. / Tél.

Dr. No. / Op. Bus. Date Y/A M D/J

If not shown, please print last name, then first name and address. / *S'ils ne sont pas indiqués, veuillez écrire votre nom de famille, suivi de votre prénom et adresse.*

Class of Licence Desired
Catégorie de permis désirée

Sex / Sexe	Date of Birth / Date de naissance	Licence / Permis
	Y/A M D/J	Cl/Cat. Cond./End. Rest./Aut.

Ref. or Driver's Licence No. / *N° de réf. ou du permis de conduire*

Reason for Medical / *Raison de l'examen*

1. ☐ Original Ont. Licence / *Premier permis en Ont.*
2. ☐ Regular Re-exam / *Réexamen de routine*
3. ☐ Change of Class / *Changement de catégorie*
4. ☐ Special Min. Request / *Demande spéciale du min.*

Office Use Only / *Réservé au bureau*
Wavr of Record
Re
M Gr
Wavr
Med Cond
Mo to Med
Tr Code R

Driver's Certificate and Release of Information

I certify that the foregoing information is to the best of my knowledge correct and agree to this report and any future report from this examination only being given to the Ministry of Transportation. **The fee for this examination is not the responsibility of the ministry or its service provider.**

Attestation du de la conducteur(trice) et divulgation des renseignements

J'atteste par la présente que, pour autant que je le sache, les renseignements suivants sont exacts et je consens à ce que ce rapport et tout autre rapport ultérieur relatif à cet examen ne soient remis qu'au ministère des Transports. ***Il n'incombe pas au ministère ni à son fournisseur de services d'acquitter les droits de cet examen.***

Telephone Number
Numéro de téléphone Business / *Travail* _____ Home / *Domicile* _____

Driver's Signature / *Signature du/de la conducteur(trice)* _____ Date Y/A M D/J

Complete Health History

Antécédents médicaux

To be completed by examining physician.
YES answers should be explained on the reverse side under History Details.

Le présent rapport doit être rempli par le médecin effectuant l'examen.
Veuillez expliquer au verso les réponses ***affirmatives.***

		Yes/Oui	No/Non
1.	Diseases of Senses (Deafness, Vertigo, Visual Deficiencies, etc.) / *Maladies touchant les sens (surdité, vertige, défaillances visuelles, etc.)*	☐	☐
2.	Cardiovascular Diseases (Heart Failure, Angina, Infarction, Embolism, Arrhythmia, Syncope, Surgery, etc.) / *Maladies cardio-vasculaires (insuffisances cardiaques, angine, infarctus, embolie, arythmie, syncope, chirurgie, etc.)*	☐	☐
3.	Respiratory Diseases (Asthma, Chronic Bronchitis, Emphysema, etc.) / *Maladies respiratoires (asthme, bronchite chronique, emphysème, etc.)*	☐	☐
4.	Diseases of the Musculo-Skeletal System (Fracture(s) or Amputation, Arthritis, etc.) / *Maladies touchant le système musculo-squelettique (fracture(s) ou amputation, arthrite, etc.)*	☐	☐
5.	Metabolic Diseases (Diabetes (+) (-), Hypoglycemia, Thyroid, etc.) / *Maladies touchant le métabolisme (diabète (+) (-), hypoglycémie, thyroïde, etc.)*	☐	☐
6.	Psychiatric Disorders (Psychoneurosis, Psychosis, etc.) / *Troubles psychiatriques (psychonévrose, psychose, etc.)*	☐	☐
7.	Addictions (Alcohol, Sedatives, Tranquillizers, Narcotics, etc.) / *Dépendances (alcool, sédatifs, tranquillisants, stupéfiants, etc.)*	☐	☐
8.	Other Diseases (Blackouts, Fainting Spells, Anemia, Cancer, Blood Dyscrasia, etc.) / *Autres maladies (voiles noirs, évanouissements, anémie, cancer, dyscrasie, etc.)*	☐	☐
9.	Neurological Diseases (Seizures, Cerebrovascular Diseases, Parkinson's Disease, Multiple Sclerosis, Dementia, Head Injury, Mental Retardation, etc.) / *Maladies neurologiques (crises, maladies cérébro-vasculaires, maladie de Parkinson, sclérose en plaques, démence, traumatisme crânien, arriération mentale, etc.)*	☐	☐

Date of first seizure _____ / *Date de la première crise* _____

Date of last seizure _____ / *Date de la dernière crise* _____

Date of Examination Y/A M D/J / ***Date de l'examen***

SR-LC-08005-02

Medical Examination / *Examen médical*

Height / *Taille* _____ Weight / *Poids* _____

1. Eyes / *Yeux*	Acuity without glasses / *Acuité visuelle sans verres*	Acuity with Glasses / *Acuité visuelle avec verres*	Horizontal Field of Vision / *Champ de vision horizontal*
Right / *Droit*	20/ _____	20/ _____	Normal / *Normal* ☐ Restricted / *Restreint* ☐
Left / *Gauche*	20/ _____	20/ _____	Normal / *Normal* ☐ Restricted / *Restreint* ☐
Both eyes together / *Les deux yeux ensemble*	20/ _____	20/ _____	Normal / *Normal* ☐ Restricted / *Restreint* ☐

Squint, disease or eye injury / Strabisme, maladie ou lésion oculaire _____

Indicate type of tests given / *Indiquer le type d'examen effectué* Snellen ☐ Other / *Autre* _____

2. Hearing / *Ouïe* Meets standards defined in the H.T.A. with or without a hearing aid. *Respecte les normes décrites dans le Code de la route avec ou sans prothèse auditive.* Yes / *Oui* ☐ No / *Non* ☐

3. Heart / *Coeur* Apical Rate / *Fréquence apicale* _____ Rhythm / *Rythme* _____

Murmurs / *Souffles* _____ B.P. / *P.S.* _____ / _____

4. Locomotor / *Locomotion* Upper Extremity / *Membres supérieurs* _____ Lower Extremity / *Membres inférieurs* _____ Neck and Lumbar / *Cou et région lombaire* _____

5. Chest / Abdomen / *Poitrine / Abdomen* _____

6. Urinary / *Voies urinaires* Urine Protein / *Protéine urinaire* _____ Glucose _____

7. Diabetes / *Diabète* Yes / *Oui* ☐ No / *Non* ☐ Type _____

Treatment / *Traitement* Diet alone / *Régime seulement* ☐ Oral medication (amt per 24 hrs.) / *Médicaments pris par voie orale (dose quotidienne)* ☐ _____ Insulin (amt per 24 hrs.) / *Insuline (dose quotidienne)* ☐ _____

8. Hypoglycemia / *Hypoglycémie* Frequency / *Fréquence* _____

Circumstances / *Circonstances* _____

Loss of Consciousness / *Perte de conscience?* _____ Decrease in cognition, etc. / *Perte des facultés cognitives, etc.* _____

9. Neurological / *Affections neurologiques:* Gait and Stance / *Démarche et position* _____ Reflexes / *Réflexes* _____

Tremor / *Tremblement* _____ Coordination _____

10. Mental Competence / *Aptitude mentale* _____ Judgement / *Jugement* _____

Evidence of Emotional Disorder / *Signe de trouble émotionnel*

	Yes / *Oui*	No / *Non*		Yes / *Oui*	No / *Non*		Yes / *Oui*	No / *Non*
Instability / *Instabilité*	☐	☐	Psychosis / *Psychose*	☐	☐	Drug Habituation / *Toxicomanie*	☐	☐
Neurosis / *Névrose*	☐	☐	Alcoholism / *Alcoolisme*	☐	☐			

History Details and Summary / *Détails sur les antécédents et résumé*
(Including details of all medication prescribed and dosage, degree of decompensation in cardiovascular diseases) / *(Y compris les détails relatifs à tous les médicaments prescrits et la posologie; le degré de décompensation pour les maladies cardio-vasculaires)*

_____

_____

_____

_____

_____

How long has this person been your patient? / *Depuis combien de temps soignez-vous cette personne?* _____ Family Physician / *Médecin de famille* ☐ or / *ou* Certified Specialist in / *spécialiste qualifié(e) en* _____

Please Print / *en lettres moulées s.v.p.*
Physician's Name / *Nom du/de la médecin* _____ Signature _____

Address / *Adresse* _____ Date Y/A M D/J

Information in this form is collected under the authority of the Highway Traffic Act, R.S.O 1990, c.H.8 and regulation 340/94 21.2 thereunder and is used to evaluate eligibility to obtain and maintain a driver's licence. Direct inquiries to: Team Leader, Medical Review Section, Driver Improvement Office, Licensing Services Branch, Bldg A, 2680 Keele St., Downsview, Ontario M3M 3E6 (416) 235-1773 or 1-800-268-1481.

Les renseignements figurant sur cette formule sont recueillis en vertu du *Code de la route*, L.R.O 1990, chap. H. 8, et du règlement 340/94 21.2 pris en application du *Code*. Ces renseignements sont utilisés pour évaluer l'admissibilité à l'obtention et la conservation du permis de conduire. Veuillez faire parvenir vos demandes de renseignements à l'adresse suivante : Au chef d'équipe, Section d'étude des dossiers médicaux, Bureau de perfectionnement en conduite automobile, Direction des services de délivrance des permis et d'immatriculation, Édifice A, 2680, rue Keele, Downsview (Ontario) M3M 3E6 (416) 235-1773 ou 1-800-268-1481.