PEI Council of People with Disabilities

Abilities@Work Program

Employer Application

5 Lower Malpeque Road Unit 2,
Landmark Plaza Charlottetown, PE C1E-
1R4 Tel: (902) 940-2434
Toll Free: (888) 473-4263 Fax: (902) 566-1919
E-Mail: abilities@peicod.pe.ca Web: www.peicod.pe.ca

Name of Business _____

Contact Person _____ Supervisor(s) _____

Mailing Address _____ City _____ Postal Code _____

Phone _____ Fax _____ Email _____

Tentative Start Date _____ Tentative End Date _____ # Weeks _____

(***Please note: participant will not be subsidized if they start working prior to approval of Employer Agreement***)

Hours/Week _____ Wage/Hour $_____ Hours/Day _____ Work Days _____

Employer Subsidy Percentage – 50% *Abilities@Work* Subsidy Percentage – 50%

Please note any special requirements of the job and if the employer or participant provides these (i.e., shift work, flexible hours, specialized clothing, licenses, special courses, certificates, *WHMIS*, *CPR* etc.):

_____

_____

Are you seeking funding for a currently vacant job position with your company? ☐ Yes ☐ No

Is this position advertised? ☐ No ☐ Yes If yes, where_____

If the *Abilities@Work* participant performs well during the subsidy term, would your operations support retaining the participant post-subsidy? ☐ Yes ☐ No

Has your company previously participated in a wage subsidy program? ☐ Yes ☐ No

If *yes*, did your company retain the funded employee(s) post-subsidy? ☐ Yes ☐ No

How many funded employees do you currently/will have on staff? _____ ☐ None

Are there any employees on lay/off and/or waiting notice of recall? ☐ Yes ☐ No

Will the subsidy result in the displacement of existing employees? ☐ Yes ☐ No

Is there a labour stoppage or labour-management dispute in progress? ☐ Yes ☐ No

Are you related to the below participant/potential employee? ☐ Yes ☐ No

FINANCES

Is the employer able to provide 100% of the 11.58% MERCs (CPP, EI, vacation)? ☐Yes ☐ No

How are your financial records kept? ☐Manually or ☐Electronically

Name of Bookkeeper_____Phone #:_____E-mail Address: _____

Insurance Coverage

Workers Compensation: ☐Yes ☐ No WCB Rate/$100 for this position: _____

Private Insurance: ☐Yes ☐ No Name of Insurance Provider:_____Policy #: _____

Previous claims: ☐ No ☐Yes If yes, when: _____

PARTICIPANT INFORMATION

If you have a participate you would like to hire with Abilities@Work *funding, please indicate below :*

Participant Name_____Position _____

Mailing Address_____City _____ Postal Code _____

Phone _____ Email _____

Have you interviewed this person? ☐Yes ☐ No

Do you believe this person has the qualifications to perform this position? ☐Yes ☐ No

JOB DESCRIPTION

Pleas attach a job description of all of the duties the participant will be performing during the subsidized work term.

DECLARATION

I, the undersigned declare that:

a. I have read and understood the information provided in this application;
b. The information I have provided to the *Abilities@Work* program in this application and supporting documentation is true, accurate and complete;

Printed Name of Employer Representative	*Employer Representative Job Title*
Signature of Employer Representative	*Date*

The *Abilities@Work* program is funded in part by the *Government of Canada's Opportunities Fund for Persons with Disabilities* program.