

SIoux LOOKOUT AREA ABORIGINAL MANAGEMENT BOARD
P.O. Box 56, Sioux Lookout, Ontario P8T 1A1, Tel (807)-737-4047, Toll free 1-800-563-2183
INDIGENOUS SKILLS AND EMPLOYMENT TRAINING PROGRAM

ADVANCE OR PAYMENT CLAIM (MONTHLY)

PROJECT START DATE:

PROJECT END DATE:

Name of Employer/Sponsor:				File Number:	
Mailing Address:		Period Covered by this claim (dd/mm/yy): From: ____/____/____ To: ____/____/____			
City/Town:	Province:	Postal Code:		Is this your Final Claim?	
Name of Contact Person:		Tel #: () -		YES: () NO: ()	
Wage Costs - Staff (Occupation) Col. 1 - Fill out columns 1 – 5	No. of Staff Col.2	Hours Claimed Col.3	Hourly Rate Approved Col.4	Claimed for this period (To nearest dollar) Col.5 (Col.3X4)	SLAAMB Office Use Only Col. 6
SUBTOTAL					
Mandatory Employment Related Costs			_____ %		
Overhead Costs					
Training Costs					
Special Costs					
TOTAL					
Employer Certification: I certify the information is true and correct to the best of my knowledge and claimed in accordance with the agreement.					
SIGN NAME:		PRINT NAME:		DATE:	
SLAAMB OFFICE USE ONLY				OFFICIAL USE	
INFORMATION:				Funding Source	\$ Amount
Certified to be in accordance with the terms and conditions of the agreement				Amount of Payment	
Project Officer _____		Date _____			
Finance Clerk _____		Date _____		\$ _____	
Authorized	Payment Issued			Date Captured	
_____ Coordinator Initials	_____ Finance Officer	_____ Date	_____ Cheque No.		

PLEASE ENSURE THAT AN ACTIVITY REPORT & TIME SHEET(S) IS INCLUDED WITH THIS PAYMENT CLAIM