INTERNATIONAL
COMPETENCY ASSESSMENT BOARD

I-CAB Trust Fund Application

Return Application to registrar@i-cab.org

SECTION 1: Personal Information

Surname	First Name	Middle Initial
Home Address	**City/Province/State**	**Postal Code/Zip Code**
Telephone	**Email**	

Select the industry and jurisdiction of the assessment that you wish to complete (go to www.i-cab.org for listing):

Industry	Jurisdiction

SECTION 2: Criteria

Those eligible to apply for the I-CAB Trust Fund must meet one of the following criteria:

1	**Age**: under the age of 25	Complete **Section 3**
2	**Aboriginal/Indigenous Status:** Currently holds Aboriginal/Indigenous status	Complete **Section 4**
3	**Registered Apprentice:** entering the workforce following completion of an apprenticeship program	Complete **Section 5**
4	**Post Secondary Graduate:** entering the workforce following post secondary education or similar in the field of occupational health and safety	Complete **Section 6**
5	**Re-employment Program:** entering the workforce following a re-employment program	Complete **Section 7**
6	**Retraining Program:** entering the workforce following retraining after suffering a workplace injury	Complete **Section 8**

SECTION 3: Proof of Age

Provide proof of age by attaching a copy (front and back) of one piece of government-issued photo identification. Approved identification includes, but is not limited to:

- Driver's License
- Passport
- Citizenship card
- Permanent Resident card
- Birth Certificate

SECTION 4: Proof of Status

Provide proof of Aboriginal/Indigenous status by attaching a copy (front and back) of government-issued status card/identification.

SECTION 5: Proof of Apprenticeship

Please specify the institution through which you have completed the Apprenticeship Program and attach proof of completion.

Institution	
Program Completed	
Date of Completion	

SECTION 6: Post Secondary Graduate

Please specify the institution through which you have completed the Occupational Health and Safety Program and attach a copy of the certificate/diploma to serve as proof of completion.

Institution	
Program Completed	
Date of Graduation	

SECTION 7: Re-employment Program

Please complete the information below regarding the re-employment program:

Re-employment Agency		Telephone
Address	**City/Province/State**	**Postal Code/Zip Code**

Agency Representative Declaration

I hereby certify that the individual stated above in Section 1 of this Trust Fund Application was enrolled in a re-employment program with our organization.

Agency Representative Full Name	Email	Telephone
Signature	**Date**	

I-CAB Trust Fund Application

Return Application to registrar@i-cab.org

SECTION 8: Retraining Program

Please have a representative from the Workplace Compensation organization complete the following declaration to serve as confirmation that you are currently enrolled in a return to work retraining program or attach an official Workers' Compensation document that would state the same (i.e. that you are currently enrolled in a retraining program through a Workers' Compensation organization).

WCB Representative Declaration

I hereby certify that the individual stated above in Section 1 of this Trust Fund Application was enrolled in a retraining program with our organization.

WCB Representative Full Name	Email	Telephone

Signature	Date

SECTION 7: Applicant Declaration

I hereby certify that all the above information is complete and true. I also understand that the information disclosed on this Trust Fund Application will only be used to complete an evaluation of the application and/or for the administration and operational purposes of I-CAB.

Signature	Date