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| P.O. BOX 2415**EDMONTON, AB T5J 2S5**FAX: 780-427-5863**1-800-661-1993** |  | C1413COMPUTER TRAINING SERVICESTraining Services Referral  |
| **WORKER DETAILS** | Provider’s Reference Number0WJ1 | WCB Claim Number[Claim#] |
| Surname[Surname] | First Name and Initial[FirstName] | Phone Number  | Date of Birth *(yyyy/mm/dd)*  |
| Provider Location707 – 14 St NW, Calgary, AB | Claim Owner  | Claim Owner Phone Number  |

**SERVICE REQUEST**

This referral authorizes the provider to schedule the Worker into the following courses. Please select all levels required.

[ ]  **Level 1 Computer Training** – Basic/beginner level skills

[x]  **Level 2 Computer Training** – Intermediate level skills

[x]  **Level 3 Computer Training** – Advanced level skills

Training is requested to help *[First Name]* secure employment as *[Job Title]*

**\*\*\*Delete section if training is not for standalone one to one\*\*\***

If the training is for stand alone one to one training, please indicate:

* Reason for standalone: *e.g. Computer training [insert what level] was requested to (insert reason for referral e.g., get basic computer skills to participate in a job search, to help increase employability, assist with modified placement, etc:*
* If not a full level what computer skills required?:
* Number of hours:
* Date of Health Care Strategy approval:

**\*\*\*End stand alone one to one details\*\*\***

**Additional information**

*If none, enter “N/A”.*

**\*\*For Claim Owner:**

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| --- |
| *Please submit referral to authorized provider by email. Email subject line should read****[First Name] [Last Initial] – [Claim Number]*** |