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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 Number  0WJ1 | WCB Claim Number  [Claim#] |
| Surname  [Surname] | | First Name and Initial  [FirstName] | | Phone Number | Date of Birth *(yyyy/mm/dd)* |
| Provider Location  707 – 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

**Level 2 Computer Training** – Intermediate level skills

**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:**

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