



**Support our Troops**  
 4210 Labelle Street, Ottawa ON K1A 0K2  
 Tel: 613-943-8756 / 1-888-753-9828 Fax: 613-996-4207  
 E-mail: \_\_\_\_\_@cfmws.com

**Schedule A**

Surname	Given Name	Initial(s)
CF One Number	Date of Birth	

**IF MILITARY**

Rank	Reg Force <input type="checkbox"/>	Reserves <input type="checkbox"/>	Class _____	Service Number
Enrolment Date <small>(dd/mm/yy)</small>	Contract End Date <small>(dd/mm/yy)</small>			Release Date <small>(dd/mm/yy)</small>

**IF NOT MILITARY**

State relationship to the CAF Member

	Yes	No	Day	Month	Year
Have you ever voluntarily filed for protection under the Bankruptcy and Insolvency Act? (assignment in bankruptcy, consumer proposal or orderly payment of debts program)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Are you awaiting discharge from bankruptcy, consumer proposal or an orderly payment of debts program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Are you in the process of being released from the CF or are you contemplating taking your release within the next 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**MARITAL STATUS**

Single  Married  Common-Law  Separated  Divorced  Widow

**SPOUSE'S INFORMATION**

Surname	Given Name	Initial(s)
CF One Number (if applicable)	Date of Birth	

**IF MILITARY**

Rank	Service Number
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**CONTACT INFORMATION**

Mailing Address	City	Province	Postal Code
Home/Cellular Phone	Applicant Work Phone		Spouse Work Phone
Applicant Email		Spouse Email	

**PARTICULARS OF PERSONS RESIDING IN HOUSEHOLD**

Name	Relationship to Applicant	Date of Birth	Other comments if required

**DISCLOSURE & AUTHORIZATION**

I hereby verify that all of the information I have provided with respect to my request for application for financial assistance from Support Our Troops, is true. This will also confirm that I consent to the collection, disclosure and sharing of personal financial information by SOT authorized personnel/SISIP FCs/Chain of Command as deemed necessary for the sole purpose of assessing my request for this application, and for all other purposes associated with the administration of the Support Our Troops Funds and that no other use or disclosure of this information will occur without my consent, other than pursuant to the provisions of the Access to Information Act and Privacy Act.

**SIGNATURE(S)**

Applicant Signature	Date
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Spouse Signature	Date
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