

## 2025 Veterinary Student Employment Program (VetSTEP) Claim Statement

### Section 1: Applicant Information

1. Legal Name of Organization:	Please complete the following information. A Business Number is required for all registered and incorporated businesses and organizations. A Social Insurance Number is required for all individuals/sole proprietors. Please provide one or the other.
2. Business Number:	3. Social Insurance Number:
4. Complete Address (include Office No., Street Name, Box No., City, Province & Postal Code):	
5. Operating (Common) Name, if different from legal name:	
6. Name of Employer Representative (for this grant):	7. Designation:
8. Employer Representative Direct Phone Number:	9. Employer Representative Direct Email Address:

### Section 2: Employee ("Student") Information

1. Name of Student:	2. Most Recent Year Completed: <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third
3. Hourly wage for regular pay (excluding overtime or bonuses):	

### Section 3: Summary of Expenses

**Calculation of Claim** - Please complete the table below by entering the eligible costs:

Description	Hours
Hours of Paid Employment from April 6 to end of work term (August 16 or earlier)	

**Please refer to your Funding Decision Letter and/or the Veterinary Student Employment Program Terms and Conditions if you have any questions regarding eligible costs.**

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### Declaration and Signature

**I/we confirm that I/we have read and understood the objectives, principles and criteria set out in the terms and conditions of the Veterinary Student Employment Program and agree that:**

Financial, commercial, scientific or technical information provided in this claim will be treated in accordance with federal legislation, including The Access to Information Act and The Privacy Act and similar provincial Acts including The Freedom of Information and Protection of Privacy Act.

I/we understand that my personal information will otherwise only be used or disclosed with my/our consent or with other legal authority.

I/we confirm that the information provided in this claim form is, to the best of our knowledge, complete, true and correct.

I/we understand that the copy of the employee ("student") Record of Employment supplied by the employer to Manitoba Agriculture (AGR) to support this claim may be disclosed to the employee or Services Canada by AGR.

By signing below, I/we agree with the information contained in Section 4 and are authorized to submit the claim. An ink signature is required.

Signature of Employer Representative (for this grant):	Designation:
Name of Employer Representative (for this grant):	Date (yyyy-mm-dd):

- ☐ I/we acknowledge that the applicant is not a business or operation in which a government employee (as defined by the Program Terms and Conditions) is a majority shareholder.
- ☐ I/we acknowledge that the applicant's claim and the applicant's participation in the Program does not contravene the Conflict of Interest section of the Program Terms and Conditions.
- ☐ I/we have read and agree with the Terms and Conditions provided by the Program administrator in the email with the Decision Letter for this project.