



SKILLS INVENTORY

Name:	
Phone Number:	
Address:	
High School:	Completed: Yes <input type="checkbox"/> No <input type="checkbox"/> Year completed _____
Post-Secondary:	Completed: Yes <input type="checkbox"/> No <input type="checkbox"/> Year completed _____ Program: _____
Post-Secondary:	Completed: Yes <input type="checkbox"/> No <input type="checkbox"/> Year completed _____ Program: _____
Work Experience:	Company: _____ Field: _____ Start Date : _____ End Date: _____
Work Experience:	Company: _____ Field: _____ Start Date : _____ End Date: _____
Work Experience:	Company: _____ Field: _____ Start Date : _____ End Date: _____
Work Experience:	Company: _____ Field: _____ Start Date : _____ End Date: _____
Certifications/tickets	
Workshops/Short courses	