**** **Application for Incumbent Worker Training**

**Exhibit A**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Business Name:** |  | | | | | | | | | | | |
| **Address:** |  | | | | | | | | | | | |
| **Business Contact Name :** | |  | | | | | **Phone**: | | | | |  |
| **Title:** |  | | | | | **Email:** | | |  | | | |
|  |  | | | | | | | | | | | |
| **Type of Business:** |  | | Private For-Profit |  | Private Non-Profit | | |  | | Other: |  | |
| **Number of Employees:** | Fewer than 100 (25% employer cost match) | | | | | | | | | | | |
|  | 100 or more (50% employer cost match) | | | | | | | | | | | |

**Training**: Briefly describe the proposed incumbent worker training and how it will improve labor market competiveness of employee and employer, such as improved workplace efficiency, customer service, safety etc. (Attach detail course description or provide a hyperlink in the description below.)

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| Amount of IWT funds requested: | $ | Amount of Employer Match: | $ |
| Anticipated Training Start date: |  | Training End date: |  |
| Training will be provided:  On-site;  at Training Institution;  Online;  Other site (specify): \_ | | | |

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| **Training Provider Information:** | | |
| Name of Training Provider: | | |
| Contact Person: | | |
| Street/Mailing Address: | | |
| City/State/ZIP: | | |
| Phone #: | Ext. #: | E-Mail: |

**Training Considerations: (Please check all that apply)**

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|  | Training will be provided to employees who face barriers to employment  *Briefly explain:* |
|  | Training will avert layoffs  *Briefly explain:* |
|  | Training will increase wage and benefit levels of the employees trained  *Describe the increase:* |
|  | Training will result in credentials or certificates for the employees trained  *List credential or certificate:* |

**Trainees:** (Add sheet as necessary)

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|  | **Name** | **Date of Hire** | **Date of Birth\*** |
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**\*** For data entry purposes

**Employer Certifications:**

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|  | If training an employee cohort that includes employees with fewer than 6 months of employment, employer certifies that at least 51% of the cohort has been employed 6 months or longer. |
|  | Employer certifies that all listed employees meet the Fair Labor Standards Act requirements for an employer-employee relationship, and are not in managerial or professional positions within the organization. |
|  | Employer certifies they are committed to retain or avert the layoffs of the incumbent worker(s) trained. |
|  | Employer certifies that requested training does not supplant training that is routinely offered by employer. |
|  | Employer certifies they have not relocated from another US labor market within the past 120 days which caused any employee layoffs. |
|  | Employer certifies they are current in unemployment insurance, workers’ compensation taxes, penalties and/or interest or related payment plan. |
|  | Employer understands false information or misrepresentations will result in cancellation and non-payment. |
|  | Employer will adhere to all reporting requirements and to respond to a Customer Satisfaction Survey(s) if asked; |
|  | The employer will not discriminate against any individual on the basis of race, color, religion, sex (including pregnancy, childbirth, and related medical conditions, sex stereotyping, transgender status, and gender identity), national origin (including limited English proficiency), age, disability, or political affiliation or belief, or, against any beneficiary of, applicant to, or participant in programs financially assisted under Title I of the Workforce Innovation and Opportunity Act, on the basis of the individual's citizenship status or participation in any WIOA Title I-financially assisted program or activity. The nondiscrimination assurances at 29 CFR Part 38.25 apply to this contract |

**As the authorized representative of the employer submitting this application, I hereby certify the information contained in this application is true and accurate and reflects the intentions of the IWT program:**

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| Employer Signature: |  | | | |
| Printed Name: |  | | | |
| Title: |  | |  | |
| Date: |  |  | |  |

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| **FOR INTERNAL USE ONLY** | | | | | | | | |
| Training occupation is:  In Demand  Balanced  In Decline (justification attached) | | | | | | | | |
| Proposal Review Date: | |  | Approve Disapprove | | Approved Funding Amount: | | **$** |  |
| Approved by: |  | | | Date: | |  | |  |
|  | | | | | | | | |
| Notes: | | | | | | | | |