

PROVIDER APPLICATION FOR TRAINING SERVICE ELIGIBILITY – REVISED 2/04

For WIA Office Use Only	
Date Received:	_____
Date Reviewed:	_____
LWIB Approved/Denied:	_____

1. Name of Local Workforce Investment Area Where Training Program Is Offered _____			
2. Provider/Organization Name: _____		5. Facility is applying for eligibility under (pick one):	
3. Federal ID Number: _____	_____	_____	HEA Funding Title IV
4. Proprietary License #: _____	_____	_____	Registered Apprenticeship
		_____	Other
6. Does Provider Offer a Refund Policy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, briefly explain: _____			
7. Mailing Address:			
_____		_____	_____
Street or P.O. Box	City	State	Zip
8. Street Address/Location:			
_____		_____	_____
(Physical location of provider)		City	State
			Zip
9. Phone: () _____	Extension: _____	10. Fax: () _____	
11. Home Page Address: _____			
12. Contact Person/Application Respondent: _____			
13. Title: _____			
14. Address: _____			
15. Phone: () _____	Extension: _____		
16. E-mail Address: _____			
Certification: I certify that the information given in this application is correct and true to the best of my knowledge and was prepared in accordance with the accompanying instructions. Willfully making false statements on this application or any attachments will deem this provider ineligible to provide services under the Workforce Investment Act of 1998.			
17. Signature: _____			
		18. Title: _____	
19. Submittal Date: _____			

TRAINING PROGRAM/COURSE INFORMATION – REVISED 2/04

1. Training Program Name: _____ 2. CIP Code: _____

3. Program is applying for consideration of (pick one): Initial eligibility _____ or Subsequent Eligibility _____

4. The Provider has been operating this program (*circle one*):

Less than one year More than one year More than three years More than five years

5. ALL required performance data has been submitted for this training program. Yes No

6. If no, provide written justification for non-submission of data.

7. If answer to question 5 is no, describe plans to track and record the required data for subsequent eligibility.

8. Is Program HEA Approved: Yes No 9. Upon completion, what type of Degree/Certificate is awarded? _____

10. Training Program Length (*see instructions*): _____

Days Weeks Months Years Clock Hours Credit Hours Semesters Quarters Other (*if other, explain*)

11. Training Program Description (*see instructions*):

TRAINING PROGRAM LOCATION AND PERFORMANCE INFORMATION – REVISED 2/04

1. State: _____ 2. County: _____
 3. LWIA: _____ 4. Campus: _____

5. Physical Address of Program:

City State Zip

6. Is this program considered a distance learning program? Yes No

7. Contact Person for this Program: _____ Title: _____

8. Mailing Address of Contact Person:

City State Zip

9. Contact Phone: (____) _____ Extension: _____

10. Contact E-mail Address: _____

11. Is this site in compliance with the Americans Disability Act (ADA)? Yes No

Training Program Costs:

12. Tuition	13. Fees	14: Textbooks	15: Supplies/misc.	16: Total:

PERFORMANCE INFORMATION

To Be Completed by Facility Staff

To Be Completed By LWIA Staff

Participant Universe:

WIA Participants:

17. Reporting Period From _____ To _____

22. Reporting Period From _____ To _____

18. Number of Participants _____

23. Entered Employment Rate of Completers _____%

19. Completion Rate _____%

24. Retention Rate of Completers _____%

20. Entered Employment Rate _____%

25. Hourly Wage of Completers \$ _____

21. Hourly Wage at Placement \$ _____

26. Credential Rate _____%

In accordance with 122 (d)(1)(A) of the WORKFORCE INVESTMENT ACT (WIA), this facility will attest to the fact that the above performance data submitted is verifiable by program and can be made available for review upon request.

Signature: _____ Title: _____

Date: _____