



Employed Worker Training Agreement

SECTION 1: GENERAL INFORMATION					
Organization Name:					
Street Address:					
City & County:		Zip Code:			
Authorized Contact Person:		Title:			
Telephone Number:		Fax Number:			
Email Address:		Website Address:			
Date of Establishment:		Years in Business:		# FT Employees:	
Are you current on all Federal, State, and Local Taxes?			<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> TAX EXEMPT		
What is the legal structure of your organization?					
What is your organization's primary SIC Code?			Check your SIC Codes here: Miami-Dade Monroe		
What are your organization's other SIC Codes?					
What is your Federal Employer Identification Number (EIN)?			Learn about EINs here: EIN		
What is your Unemployment Compensation (UC) ID#?			Learn about UC here: UC		
What is your Florida Sales & Use Tax (FSUT) number?			Learn about FSUT here: FSUT		
Please describe your business, its products and/or services, and your customer base:					
Please describe in detail need for training current workforce:					
Training Start Date:					
(a) Grant Request Dollars:	\$	-	(e) Total Number of Trainees		1
(b) Your Matching Funds:	\$	361.97	(f) SFW Cost Per Trainee: (f = a / e)	\$	-
(c) Total Cost: (c = a + b)	\$	361.97	(g) Current Employee Average Hourly Wage:	\$	12.20
(d) Matching Fund %: (d = b / c)		100.0%	(h) Post Training Average Hourly Wage:	\$	12.57
Will this training avert any lay-offs at this location?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, how many?			
Will this training create any vacancies that SFW can help fill?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, how many?			
Will improve long-term wage levels of trainees	<input type="checkbox"/> YES <input type="checkbox"/> NO	Will improve short-term wage levels of trainees	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Critical to long-term visibility of our organization	<input type="checkbox"/> YES <input type="checkbox"/> NO	Critical to short-term viability of our organization	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Will help prevent organization having to relocate operations	<input type="checkbox"/> YES <input type="checkbox"/> NO	Will lower employee turnover	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Is your organization receiving State or Federal funding for this training request			<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes Please Explain	
Is this training for Incumbent employees			<input type="checkbox"/> YES <input type="checkbox"/> NO		
We have identified 0 employees that meet the definition of self-sufficiency as defined by SFWIB but will not be retained unless additional training or services are received.					
CERTIFICATION BY CAREER CENTER DIRECTOR OR AUTHORIZED MANAGEMENT REPRESENTATIVE					
Contract Number			Funding Source		
I hereby certify that the information listed above and attached to this application is true and accurate. I am aware that any false information or intended omissions may subject me to civil or criminal penalties for filing of false public records and/or forfeiture of any training award approved through this request.					
NAME:			TITLE:		
_____			_____		
SIGNATURE:			DATE:		
_____			_____		

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Section 2: Training Project Detail															
#	Last Name	First Name	Department	Job Title (Current)	Job Title (Post Training)	Type of Training	Cost per trainee	Limited English Needs (Yes or No)	Certification	Total Hours Paid Durring Training	Is Employee Self-Sufficient as defined by SFWIB (Yes or No)	Employee(s) Current Wage	Employee(s) Post Training Wage	% of Employee Fringe Benefit	Employer Match Wage & Benefits
1	Abuabara	Carlos	Maintenance	Facility Main Tech Dir.	Same	CPR/First Aid & Essential Learning	\$79.11	No	CPR License & Certificate of Comp.	23	No	\$ 12.20	\$ 12.57	29%	\$ 361.97
2															\$ -
3															\$ -
4															\$ -
5															\$ -
6															\$ -
7															\$ -
8															\$ -
9															\$ -
10															\$ -
11															\$ -
12															\$ -
13															\$ -
14															\$ -
15															\$ -
16															\$ -
17															\$ -
18															\$ -
19															\$ -
20															\$ -
21															\$ -

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SECTION 3: TRAINING PROGRAM BUDGET			
Category	Grant Request	Employer Match	Total
1 Trainee Wages & Benefits	Cannot Fund with Grant Dollars	\$ 361.97	\$ 361.97
2 Training Equipment Purchase		\$ -	
3 Facility Usage		\$ -	
a		\$ -	
b		\$ -	
c		\$ -	
d		\$ -	
4 Travel, Food, & Lodging		\$ -	
a		\$ -	
b		\$ -	
c		\$ -	
d		\$ -	
5 Instructor Wages/Tuition		\$ -	
a		\$ -	
b		\$ -	
c	\$ -		
d	\$ -		
e	\$ -		
f	\$ -		
g	\$ -		
6 Curriculum Development	\$ -		
a	\$ -		
b	\$ -		
c	\$ -		
d	\$ -		
7 Materials, Supplies, & Textbooks	\$ -		
a	\$ -		
b	\$ -		
c	\$ -		
d	\$ -		
e	\$ -		
f	\$ -		
8 Other Cost	\$ -		
a	\$ -		
b	\$ -		
c	\$ -		
d	\$ -		
Sub Total			
9 Indirect Costs			\$ -
a <i>Relevant description</i>			\$ -
b			\$ -
TOTALS	\$ -	\$ 361.97	\$ 361.97

SECTION 4: TRAINING PROVIDER INFORMATION

Training Provider Name (1):		
Street Address:		Type of Trainer:
City & County:		Zip Code:
Authorized Contact Person		Title:
Telephone Number:		Fax Number:
#	Training Description	Training Location
1		
2		
3		

SECTION 4: TRAINING PROVIDER INFORMATION

Training Provider Name (2):		
Street Address:		Type of Trainer:
City & County:		Zip Code:
Authorized Contact Person		Title:
Telephone Number:		Fax Number:
#	Training Description	Training Location
1		
2		
3		

Attach Curriculum Outline and Identify Certificate or Credential Received

SECTION 5: EMPLOYER FINANCIAL VIABILITY

Attach your most recent tax return, a copy of your occupational license, and the W-9 Form.

SECTION 6: CERTIFICATION BY AUTHORIZED EMPLOYER REPRESENTATIVE

As an authorized representative of the organization applying for the "Customize Training Award", I hereby certify that the information listed above and attached to this application is true and accurate. I am aware that any false information or intended omissions may subject me to civil or criminal penalties for filing of false public records and/or forfeiture of any training award approved through this program.

NAME: _____

TITLE: _____

SIGNATURE: _____

DATE: _____

SECTION 6: CERTIFICATION BY AUTHORIZED EMPLOYER REPRESENTATIVE

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#	Training Description	Training Location
1		
2		
3		

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Training Provider Name (2):		
Street Address:		Type of Trainer:
City & County:		Zip Code:
Authorized Contact Person		Title:
Telephone Number:		Fax Number:
#	Training Description	Training Location
1		
2		
3		

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NAME: _____

TITLE: _____

SIGNATURE: _____

DATE: _____