**OJT/SE AND TRAINEE INFORMATION FORM**

**ATTACHMENT B**

**Employer/Business Name**:       **Contract #**:       **Trainee #**:

**Program/Service Provider**:

**Funding Source**:

[ ]  WIOA/DW [ ]  WIOA Youth

[ ]  WIOA/Adult [ ]  Other:

|  |  |  |  |
| --- | --- | --- | --- |
| Trainee’s Name (Last, First): |       | Trainee’s Social Security #(last four digits): |       |
| Job Title: |       |
| Trainee’s Phone No: |       | Trainee’s Emergency Phone No: |       |
| Trainee’s Address: |       | City: |       | State: |       | Zip: |       |

a. Proposed OJT/SE training dates: Begin:       End:

b. Local Employer size:       Total trainees:

c. Duration of contract: Hours:       Days:       Weeks:       (not to exceed six months)

d. Trainee(s) Work Days/Hours (include lunch break):

e. Trainee has been unemployed and/or receiving UI longer than 21.5 weeks [ ]  Y [ ]  N

f. Critical Occupational Cluster: [ ]  Y [ ]  N

| 1. **Work Week Hours** | **2**. **Total Training Hours** | **3. Wage Per Hour** **($ /hr)** | **4. Hourly Reimbursement****($ /hr, %)** | **5. Employer Wage Match****($ /hr, % )** | **6. Total Payment to Employer** |
| --- | --- | --- | --- | --- | --- |
|       |       |       |       |       |       |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Employer Address:** |       | **City:** |       | **State:** |       | Zip: |       |
| **Supervisor’s Name:** |       | **Title:** |       | Phone: |       |
| **Alternate Supervisor’s Name:** |       | **Title:** |       | Phone: |       |

**REIMBURSEMENT SCHEDULE**:

**ATTACHMENT B**

EMPLOYER will be reimbursed the wages agreed to under the terms of this CONTRACT upon the submission of signed timesheets (both EMPLOYER and trainee) to SERVICE PROVIDER attesting to the time worked during the period for reimbursement. Payments will be processed in accordance with the payment schedule agreed upon. EMPLOYER will attach timesheets to billing and must keep copies in trainee files. (See *OJT/SE Timesheet*)

1) Employer Paid Benefits [ ]  Yes [ ]  No If yes, which of the following benefits does the business provide?

|  |  |
| --- | --- |
| [ ] Health/Medical Insurance | [ ]  Sick Leave |
| [ ]  Dental Insurance | [ ]  Vacation |
| [ ]  Pension/Retirement Plan | [ ]  Other(specify):       |

2) Date benefits will begin: