CareerSource NORTH FLORIDA

Customized Employed Worker Training Application

Section 1. Company Information

Company Name: _____ FEIN: _____

Address: _____

City: _____ State: FL _____ ZipCode: _____

Mailing address (if different): _____

City: _____ State: FL _____ ZipCode: _____

Contact Person: _____ Title: _____

Phone: _____ Email: _____

Company Website: _____ EFM username: _____

Years in Business at this Location/In this region: _____

Legal Structure of Organization: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Non-profit ☐ Government

Carries Workers' Compensation Insurance? ☐ Yes ☐ No

Current on all State and Federal tax obligations? ☐ Yes ☐ No

Receiving or applying for other public training funds? ☐ Yes ☐ No

Outstanding liens, judgments, or other defaults? ☐ Yes ☐ No

Number of Employees: _____ Full-time _____ Part-time

Are employees required to be union members? ☐ Yes ☐ No

If yes, please provide contact information of union and local official:

(A request for training on letterhead indicating the need of the individuals receiving training--to obtain or retain employment--and benefits of the training for the employer should be attached.)

Primary NAICS code(s): _____

Description of your business, product(s), and/or service(s):

Minority ownership (check all that apply):

☐ Native-American ☐ Asian-American ☐ Hispanic-American ☐ African-American ☐ Woman

☐ Other _____

Company is located in:

☐ HUB-Zone ☐ Enterprise Zone ☐ Rural Area

Section 2. Training Information

O*Net code(s) and occupation title: _____

Is occupation on Targeted Occupations List? ☐ Yes ☐ No (Info purposes only: CEWT occupations do not have to be on TOL)

Description of CEWT position(s) (may also attach detailed job description(s)):

Pre-Training Wage: _____ Wage at Completion of Training: _____

Training Provider: _____ FEIN: _____

☐ Public Institution ☐ Private Institution ☐ Company Employee ☐ Private Trainer

Training Provider Address: _____

Proposed Training Dates: _____ To _____

Training Location: ☐ On-site ☐ Training Provider ☐ Other _____

(A training outline/description should be attached to this application.)

705 E. Base Street | Madison, FL 32340

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p: 866.367.4758

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Section 3. Estimated Training Program Costs

The costs listed below are ESTIMATES and in no way constitute CareerSource North Florida's contribution to this grant. However, the amounts shown below should be reasonable estimates.

Note: Training funds cannot be used to reimburse any training costs incurred before the grant is approved. Training funds must be spent on direct instruction costs. Excluded items include but are not limited to training, equipment, travel, food, lodging, trainee waged and benefits. Please take this into account when developing your budget and timeline.

Number of Trainees _____ Reimbursement Percentage Will not Exceed _____

A. Budget Category	B. Employer Contribution	C. CSNF Contribution	D. Total B+C=D	
1. Reimbursement Request: Instructor Wages/Tuition, Curriculum Development, Materials/Supplies and Textbooks			$ 0.00	
2. Other Costs (describe)			$ 0.00	
3. Travel, Food, Lodging		Grant Cannot Fund	$ 0.00	
4. Trainee Wages (including Benefits)		Grant Cannot Fund	$ 0.00	
5. Totals	$ 0.00	$ 0.00	$ 0.00	
Percentage of training costs	0.00	0.00	0.00	per trainee

Section 4. Anticipated Outcomes

Please check the boxes that apply to the anticipated outcomes of the proposed training project.

☐	Will assist with the retention of __ employees leading to a self-sufficient rate	☐	Will create _____ openings in entry-level positions
☐	Will improve the long-term wage levels of trainees	☐	Will improve the short-term wage levels of trainees
☐	Will lower employee turnover in our company	☐	Would help prevent company form having to relocate Operations
☐	Will create _____ new jobs in our company	☐	Critical to the long-term viability of our company
☐	Critical short-term viability of our company	☐	Will make this location more competitive within the company
☐	Will assist in the training of veterans	☐	Will assist in the training of minorities
☐	Will assist in the training of the disabled	☐	Will assist welfare to work participants
☐	Will increase the profitability of our company	☐	Important to the stated mission of our company
☐	Will assist in the improvement of international trade opportunities	☐	Will be an important component of our company's overall workforce employee development efforts

NOTE: The individual signing the application below must have authority to enter into contracts on behalf of the applying organization.

As an authorized representative of the organization listed above, 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.

Employer

_____
Printed Name

_____
Signature

_____
Date

Employer Services Representative

_____
Printed Name

_____
Signature

_____
Date

Approval--Comments

_____
Deborah Cohn, Deputy Director

_____
Date