**Participant Information**

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| LWIA #:       | Participant SSN: XXX-XX-     |
| Participant Name:       |  |  |
| Street Address:       | Apt.:       |
| City:      | State:      | Zip:       |
| Phone Number(s): Cell (   )    -      | Home (   )    -      | Email:        |
|  US Citizen [ ]  Yes **If Yes, Continue to #12.** [ ]  No **If No** Authorized to Work in US: [ ]  Yes [ ]  No. If yes, expiration date:   /  /    **\*** **\*If expiration date is prior to planned end date of training (#23), this training cannot be approved.** |

**Training Program Information**

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| Name of Training Institution: |  |
| Address:       | 14. City:      |
| State:   | 16. Zip:     -     | 17. Phone Number: (     )      -      Ext.:       |
| Name of Training Program:       |
|  Are Pre-Requisite Classes (**classes required to be completed prior to acceptance** **into the program**) required to complete this program? [ ]  Yes [ ]  No Are Remedial classes required to complete this program? [ ]  Yes [ ]  No  |
| What Industry Recognized Credential will be obtained upon completion?       |
| Has the participant been accepted into this ([ ]  Full Time / [ ]  Part Time) program? | [ ]  Yes [ ]  No |
| Start date of training:     /    /       | Planned end date of training:     /    /        |

**To Be Completed By Training Provider**

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| Authorized Training Provider Printed Name: |       |
| Title: |       |
| **NOTE:** The authorized training provider signature is verification that the participant has been accepted into the training program listed above. The training provider agrees to provide the Local Workforce Investment Area all class schedules, grades, progress reports, attendance reports, billing information and program outcome documentation (diploma, certificate, credentials). |
| Authorized Training Provider Signature: | Date:     /    /       |

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| **Notice of Certification:** I certify that the preceding information is correct to the best of my knowledge and that there is no intent to commit fraud. Furthermore, I understand that falsifying information or using the funds other than for the intended purpose is felony theft, and is punishable under state law by up to 7 years in prison and fines of up to $25,000. Violators may also face federal felony charges. I have the right to inspect this information and initiate appropriate corrections through the LWIA administering agency. I hereby authorize the Training Provider to release information required to verify training status from the date of signature. I agree to provide the career planner all class schedules, grades, progress reports, attendance reports, billing information and program outcome documentation (diploma, certificate, etc.) and meet all training benchmarks. Prior to the approval of any training program, the participant is required to enter into a written agreement with the State under which TAA funds will not be applied for or used to pay any portion of the costs of the training the participant has reason to believe will be paid by any other Governmental or Private source. |
| Participant Signature:       | Date:     /    /       |
| **APPEAL RIGHTS***If you disagree with this determination, you may complete and submit a request for reconsideration/appeal. A letter will suffice if you do not have an agency form. Your request must be filed with the Illinois Department of Employment Security (“IDES”) within thirty (30) calendar days after the date at the top of this letter. If the last day for filing your request is a day that IDES is closed, the request may be filed on the next day that IDES is open. Please file the request by mail to: IDES P.O. Box 19509 Springfield, IL 62794 or fax to: 217-557-4913. Any request submitted by mail must bear a postmark date within the applicable time limit for filing.* |

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| **STAFF USE ONLY** |
| The LWIA has approved the training program: [ ]  Yes [ ]  No |
|  [ ]  Applying 45 Day Extenuating Circumstances Reason:        |
|  [ ]  Applying 60 Day Proper Notification Reason:        |
|  [ ]  Applying Federal Good Cause Provision Reason:        |
|  [ ]  Applying Equitable Tolling Reason:        |
|  Printed Name of Career Planner:        | Career Planner Signature:       | Date:     /    /       |