CAPITAL REGION

CAPITAL REGION WORKFORCE PARTNERSHIP

INCUMBENT WORKER TRAINING PROGRAM APPLICATION

Applications must be submitted at least 5 working days prior to start of training.

Depending on the amount requested, Board approval may be required.

SECTION 1: COMPANY INFORMATION

PARENT OR CORPORATE NAME OF APPLYING COMPANY (AS LISTED ON IRS W9 FORM):			
PHYSICAL ADDRESS:	CITY:	STATE:	ZIP:
P.O. BOX ADDRESS:	CITY:	STATE:	ZIP:
COMPANY NAME, IF DIFFERENT:		COUNTY:	
PHYSICAL ADDRESS:	CITY:	STATE:	ZIP:
P.O. BOX ADDRESS:	CITY:	STATE:	ZIP:
COMPANY CONTACT:	PHONE:	EXT:	FAX:

TITLE:	E-MAIL:	WEBSITE:
NO. OF FULL-TIME WORKERS:	DATE BUSINESS BEGAN IN Area:	FEDERAL I.D. NO.:

TAX STATUS OF BUSINESS:	FOR-PROFIT	NOT-FOR-PROFIT (DESIGNATION)	OTHER:	
LEGAL STRUCTURE OF BUSINESS:	SOLE PROPRIETOR	PARTNERSHIP	LIMITED LIABILITY COMPANY	CORPORATION

IS YOUR COMPANY CURRENT ON ALL FEDERAL, STATE OF virginia, COUNTY, CITY, AND LOCAL TAX OBLIGATIONS?	YES	NO
IS YOUR COMPANY RECEIVING AND/OR APPLYING FOR OTHER PUBLIC TRAINING FUNDS?	YES	NO
IF YES, EXPLAIN:		
DOES YOUR COMPANY HAVE AN EQUAL OPPORTUNITY/NONDISCRIMINATION POLICY IN PLACE?	YES	NO
IS YOUR COMPANY SUBJECT TO A COLLECTIVE BARGAINING AGREEMENT?	YES	NO
IF YES AND IF UNION REPRESENTED EMPLOYEES WILL BE PARTICIPATING IN THE TRAINING ACTIVITIES OF THIS PROGRAM, IT IS REQUIRED THAT CONSENT BE OBTAINED FROM THE REPRESENTING UNION TO COLLECT THE ELIGIBLITY DATA FROM THE EMPLOYEES PRIOR TO FUNDING APPROVAL.		
IS YOUR COMPANY WILLING TO PROVIDE PROJECT OUTCOME INFORMATION TO THE Capital Region Workforce Development Board?	YES	NO

THIS COMPANY IS: (Circle ALL APPLICABLE) NATIVE-AMERICAN OWNED ASIAN-AMERICAN OWNED AFRICAN-AMERICAN OWNED HISPANIC-AMERICAN OWNED WOMAN OWNED OTHER MINORITY OWNED (SPECIFY):

PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR BUSINESS, PRODUCT(S) AND/OR SERVICE(S):

SECTION 2: General Request Information

TRAINING FUNDS REQUESTED: $	NO. OF EMPLOYEES TO BE TRAINED:
PROPOSED TRAINING START DATE:	ANTICIPATED TRAINING END DATE: (MAXIMUM OF 12 MONTHS FROM PROPOSED TRAINING START DATE)

SECTION 3: TRAINING PROVIDER INFORMATION (ATTACH ADDITIONAL SHEETS, IF NECESSARY)

THE TRAINING PROVIDER(S) WILL BE :	PUBLIC TRAINING INSTITUTION	PRIVATE TRAINING INSTITUTION	Company INSTRUCTOR
TRAINING WILL BE DELIVERED:	ON-SITE AT THE BUSINESS	AT THE TRAINING INSTITUTION	AT A REMOTE LOCATION

TRAINING PROVIDER:	CONTACT:	PHONE:	
PHYSICAL ADDRESS:	CITY:	STATE:	ZIP:

■ SECTION 4: TRAINING PROJECT INFORMATION

Please tell us a little bit about your training needs:

Question	Response
1) Briefly describe the purpose of the training to be supported	
2) How many employees will be trained?	
3) Will all employees receive the same training or are there different needs to be accomplished?	
4) What specific training topics or subjects will be covered?	
5) Please provide the job titles and hourly wages for each employee to be trained	
6) What outcomes are hoped to be achieved as a result of this training? Examples might include: # of jobs saved, # of new jobs created, lowering of employee turnover by X%, increased efficiency by X%, ability to increase work orders by x%, ability to expand sales/revenue by X% etc.	

Please list below the employees to be trained along with the total number of hours for their training, and attach a general training plan or course description if available from the training provider for each training element to be covered.

■ SECTION 5: TRAINING PROGRAM BUDGET

This section must be completed to show use of proposed training funds.

Allowable Categories for Reimbursement	Cost to Company
Instructor Fees or Tuition Costs	
Training-related rentals (Equipment, space, tools etc.)	
Materials, Supplies or Textbooks	
Instructor-related travel/food/lodging (DO NOT INCLUDE ANY SUCH COSTS FOR EMPLOYEES)	
Other (Describe)	
Total Project Amount	

If approved, the WDB may reimburse company up to 50% of the total cost identified above. Notice will contain the maximum amount to be reimbursed based on application review and approval.

SECTION 6: INDICATE WHICH CONDITION WOULD BE ADDRESSED BY THE APPLICATION: (CHECK ALL THAT APPLY; AT LEAST ONE MUST BE IDENTIFIED FOR FUNDING CONSIDERATION)

DECLINING SALES	
SUPPLY CHAIN ISSUES	
ADVERSE INDUSTRY MARKET TRENDS	
CHANGES IN MANAGEMENT BEHAVIOR OR OWNERSHIP	
PHASING OUT CERTAIN FUNCTION, INTRODUCING NEW FUNCTIONS/LINES THAT REQUIRE EMPLOYEE UPGRADES	
REQUIRED SKILL CHANGES THAT WOULD OTHERWISE REQUIRE DOWNSIZING, LAYOFFS ETC. IF NOT ADDRESSED	

Acknowledgements:

1) If an application is approved, some personal information about employees will be required. This is only for purposes of federal program funding/reporting requirements and will not be used for any other purposes. (See attached form)
2) The company will submit invoices as supporting documentation before funds will be reimbursed.
3) The company will keep records relating to approved projects for three years after training completion(s) to be made available for review upon request by the Capital Region Workforce Development Board, Commonwealth of Virginia, and/or US Department of Labor.

Signature and Certification

Signature:
Date
Typed Name
Phone/email

BY MY SIGNATURE I VERIFY ACCEPATNCE OF THE ACKNOWLEDGEMENT ABOVE, THAT THE INFORMATION IN THIS APPLICATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE THE AUTHORITY TO SUBMIT THIS APPLICATION ON BEHALF OF THE NAMED EMPLOYER.