Incumbent Worker Training Program (IWTP)

Customized Training Web-Based Application Signature Page

Certification of Employer and Training Provider:

Application Date:

Application Number:

CONSORTIUM COORDINATOR INFORMATION

Consortium Name:

Contact Name:

Street Address:

City, State, Zip:

Mailing address:

City, State, Zip:

Telephone Number:

Fax Number:

Email Address:

SAMPLE

PRIMARY TRAINING PROVIDER INFORMATION

Training Provider Name:

Authorized Application Signee & Title:

Street Address:

City, State, Zip:

Contact Person's Name:

Telephone Number:

Fax Number:

Email Address:

I hereby certify that all information provided in this application is true and correct and I am aware that false information or lack of information knowingly made or omitted may subject me to civil or criminal penalties for filing of false public records, and/or forfeiture of any training award approved under this program.
I understand that employers seeking a training award **may not select** as a training provider:

a. any entity who principal owner is an immediate family member, as defined in the Code of Governmental Ethics, of an individual in a management position with the employer who has the authority to make decisions regarding the training program; or
b. any related business such as a parent, subsidiary or partner of the employer.

In addition, if the training project outlined in this application is recommended for approval, I understand that one or more of the following items is required of employers and private training providers before the contract can be executed:

(__) Copy of the **W-9** form - Request for Taxpayers Identification Number and Certification.

(__) Stamped copy of **Disclosure of Ownership** that has been properly filed with the Secretary of State's Office if the employer or training provider is a for-profit corporation whose stock is not publicly traded. *Note*: Employers or private training providers are exempt from submitting this if they are any of the following: non-profit, publicly traded, sole proprietorship, Louisiana medical corporation, Limited Liability Company, electric or gas service corporation, state chartered bank, or partnership.

(__) A **Board Resolution** authorizing signature for the corporation for contract purposes, if the employer or private training provider is a corporation, profit or non-profit. *Note*: Employers or private training providers are exempt from submitting this if they are a partnership or an individual.

(__) Consortium Members may each need to provide a **Company Overview Form**.

Industry and Training Provider Collaboration

I hereby certify that this application is the result of a collaborative effort of all parties listed below. All parties have met to discuss training needs, costs, available resources including location of training, curriculum, equipment, materials and supplies, etc.

SAMPLE

Authorized **Consortium** Signature Date Signed

Typed/Printed Name of Authorized **Consortium** Signature

Training Provider's Authorized Application Signature Date Signed

Typed/Printed Name of **Training Provider's** Authorized Application Signature

Note: Written contract approval from LWC will be required prior to the start of any training.