



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:

**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 whose 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.

\_\_\_\_\_  
Authorized **Consortium** Signature Date Signed

SAMPLE

\_\_\_\_\_  
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.**