



**Employed Worker Training (EWT)  
Application Instructions – 10/11**

**Employed Worker Training (EWT) Program Grant Application – 2010/2011**

**SECTION 1 Company Information**

|  |  |  |
|--|--|--|
| Company Name:  |  |  |
| Street Address:  |  |  |
| City:  | Zip:                                       | County:  |
| Company Contact Person:  |  | Title:   |
| Phone:   | Ext.:                                      | Fax:   |
| Email Address:   | Website Address:                           |  |
| Years in Business:   | Total Number of Full-time Employees:       |  |
| Employer's Federal ID #:   | Sarasota/Manatee County Occupational Lic # |  |
| Unemployment Comp ID #:  |  |  |
| Does your company have ongoing training programs?                        |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has your company received EWT funds from Suncoast Workforce in the past? |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, are those employees still working for the company?               |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have there been any layoffs or furloughs in the past 12 months?          |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are there any projected layoffs or furloughs in the next 12 months?      |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your company receiving/applying for other public training funds?      |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Such as:   |  |  |
| OJT (On Job Training)  | QRT (Quick Response Training)              |  |
| IWT (Incumbent Worker Training)  | Vocational Rehabilitation                  |  |
| Other (describe):  |  |  |
| Description of your business, product(s) and/or service(s):              |  |  |

|   |  |                                      |                                      |
|---|--|--------------------------------------|--------------------------------------|
| Legal Structure of Business:  | <input type="checkbox"/> Sole Proprietor | <input type="checkbox"/> Partnership | <input type="checkbox"/> Corporation |
| Does your organization have any affiliation with the Suncoast Workforce (e.g. member of Board of Directors or subcommittee, employee's family member is a Suncoast Workforce employee, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                      |                                      |
| If yes, please explain:   |  |                                      |                                      |



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**SECTION 2 Training Project Information**

Description of the proposed training project(s): Please note that you have choices in deciding the training program that best fits your company needs as well as choices in the training organizations that will provide that service.

Describe each Training Program for which you are requesting assistance (attach additional sheets if necessary):

|   |   |  |
|---|---|--|
| Name of Training Provider(s): (If known)  |   |  |
| Name of Training Provider contact:  |   | Phone:   |
| Address:  |   |  |
| City:   | State:  | ZIP:   |
| Type of Training Provider:  |   |  |
| <input type="checkbox"/> Public training institution  | <input type="checkbox"/> Private training institution | <input type="checkbox"/> Private Instructor/Consultant |
| Does the provider have any affiliation with the Suncoast Workforce (e.g. member of Board of Directors or subcommittee, employee's family member is a Suncoast Workforce employee, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, please explain: |   |  |

|  |   |
|--|---|
| Training Title:  | Number of Training Hours:   |
| Number of trainees:  | Average Wage of Trainees:   |
| Start Date:  | End Date:   |
| Where will training be delivered?                                      | <input type="checkbox"/> Employer Location <input type="checkbox"/> Provider's Location |
| Cost of Training per employee:   | Total Cost of Training:   |
| Job titles of individuals to be trained:                               |   |
| Please provide a narrative description of the training to be provided. |   |
| Please explain why the training is needed:                             |   |



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**SECTION 2 Training Project Information (continued)**

Describe how this training will impact your organization's success. Be as descriptive as possible

| <b>Statement</b>  | <b>Yes</b>               | <b>No</b>                | <b>Describe What/How/Who/How much?</b> |
|---|--------------------------|--------------------------|--|
| Will save jobs within the company<br><i>If the training is not provided, will this result in a need to replace existing workers with workers who have the skills?</i>   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Will create new jobs within the company   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Will increase the profitability of the company<br><i>(i.e., Company is expanding and skills are necessary to meet new production or customer needs (describe).</i>  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Will improve wage levels of trainees<br><i>(The training will result in promotional opportunities and /or wage increases- describe and include the amount of any proposed increases)</i>  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Will help prevent the company from having to relocate operations  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Will lower employee turnover in the company   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Critical to the long-term viability of the company<br><i>(i.e., Manufacturing or other processes have changed or are projected to change in the upcoming 24 months and require new or different skills than currently required of employees (describe).</i> | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Critical to the short-term viability of the company<br><i>(i.e., Technology innovations require updating of employee skills (describe).</i>   | <input type="checkbox"/> | <input type="checkbox"/> |  |



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**SECTION 3 Certification by Authorized Company Representative**

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

Have you reviewed Suncoast Workforce's Employed Worker Training contract (attached) and are you willing to sign?

Yes     No

As an authorized representative of the company 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.

|             |        |
|-------------|--------|
| Signature:  | Title: |
| Print Name: | Date:  |

**Submit via email to: [jseavey@suncoastworkforce.org](mailto:jseavey@suncoastworkforce.org)**

**Or mail to:**  
Suncoast Workforce  
Employed Worker Training Program  
Attention: Jennifer Seavey  
3030 University Parkway  
Sarasota, FL 34243



SUNCOAST WORKFORCE
EMPLOYED WORKER TRAINING
EMPLOYER AGREEMENT

Member: Employ Florida

To be Completed by Employer

Employer name: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip Code Phone Number Fax Number

Employer contribution: \_\_\_\_\_

Suncoast Workforce contribution: \_\_\_\_\_

Type of training requested: \_\_\_\_\_

# of employees participating in training: \_\_\_\_\_

Beginning date of training: \_\_\_\_\_ End date of training: \_\_\_\_\_

Does your organization have any affiliation with the Suncoast Workforce (e.g. member of Board of Directors or subcommittee, employee's family member is a Suncoast Workforce employee, etc) and if so, please explain: \_\_\_\_\_

As the company representative, I agree to allow my designated number of employees (names attached) to receive specific training as authorized by our company. These employees require training to retain employment that allows for self-sufficiency. All training(s) must be requested in advance and be completed in 90 days or less. I agree to retain in employment those individuals that successfully complete the training program provided each employee continues to meet the company's performance standards.

I understand that each employee will be required to complete an intake by Suncoast Workforce staff, and I agree to coordinate this process and will submit documentation, including copies of the employees' Employment Eligibility Verification (form I-9) with supporting eligibility documentation and the Employer Assessment of Training Candidate form, two (2) business days prior to intake. Intakes must be completed by the Suncoast Workforce staff within a minimum of two (2) business days prior to training. I understand that follow-up information on the employment status (job title and salary) of participating employees is required and agree to provide this information quarterly for one year.

Authorized Company Representative Signature Print Name Date

Business Services and Outreach Officer Signature Print Name Date

Suncoast Workforce President/CEO Signature Print Name Date

An equal opportunity employer/program Auxiliary aids and services are available upon request to individuals with disabilities. TTY: dial 711.