

◀ REGION I ▶

WIA Participant Employment Information Form

Participant Name: _____ SSN: _____

Training Provider: _____ Training Program: _____

Employment type: Training Related Non-Training Related

Employer Name: _____ FEIN: _____

Employer Street Address: _____

City: _____

State: _____ County: _____ Zip: _____

Telephone: () _____ Fax: () _____

Contact Person

Street Address: _____

City: _____

State: _____ County: _____ Zip: _____

Telephone: () _____ Fax: () _____

Email Address: _____

Job Title: _____ Salary: _____

Hourly Monthly

Start Date: _____

Medical Benefits: YES NO

Hours Per Week: _____

Fringe Benefits: YES NO

Signature: _____ Date: _____

Return to: Referring Region I Case Manager