



Partner: ___ AC ___ CC ___ O ___ R
CT Contract Number
Referral Made By

CT Referral Form

_____ Customized _____ Upgrade _____ Other

EMPLOYER INFORMATION

1. Company/Association Name: _____
2. Address: _____
3. City/State/Zip: _____
4. Contact Person: _____ Title/Position: _____
5. Federal Tax ID Number: _____
6. Phone: _____ Fax: _____ E-Mail: _____
7. Describe training (attach training outline): _____

8. Training Occupation: _____

***Fill the section out if a third party vendor will accept payment on behalf of employer.**

3RD PARTY VENDOR INFORMATION

- Name: _____
- Address: _____
- Phone: _____
- Contact Person: _____
- Federal Tax ID Number: _____

PARTICIPANT INFORMATION

1. Participant Name	SSN	Trng. Occupation	Start/End Date	CT Number	Wages Start/End

2. WIA Funding Sources:

Adult.....	Total Obligated \$ _____
Dislocated Worker.....	Total Obligated \$ _____
Other (Specify): _____	Total Obligated \$ _____

3. Total number of CT training hours	
4. Total Training Cost	\$ _____
5. Reimbursement rate of _____ % (up to 50%)	\$ _____
6. CT cost per participant	\$ _____
7. Number of employee participants to receive CT in this occupation	
8. Total allowable cost	\$ _____

OAKLAND PIC, INC.

EMPLOYER

By: _____

by: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____