OJT PRE-AWARD REVIEW

1. **BUSINESS'S NAME:**
   (LIST NAME OF PARENT COMPANY, SUBSIDIARIES, ANY OTHER NAME THE ESTABLISHMENT DOES BUSINESS UNDER, OR SUCCESSOR-IN-INTEREST)

2. **CERTIFICATION:**
   (COMPLETE THE NAME, TITLE AND ADDRESS OF COMPANY OFFICIAL CERTIFYING THIS INFORMATION)

   NAME: _____ TITLE: _____

   ADDRESS: _____

3. **NAME AND ADDRESS OF FACILITY BEING CLOSED OR WHICH BUSINESS IS BEING TRANSFERRED**

   _____

4. **EMPLOYER'S STATEMENT OF JOB LOSSES AT FACILITY IDENTIFIED IN ITEM #3.**
   (INCLUDE THE NATURE OF PRODUCTS OR BUSINESS BEING TRANSFERRED)

   _____

5. **DATE THE FACILITY WILL COMMENCE OR EXPAND OPERATIONS: _____**

6. **IS WIOA ASSISTANCE BEING SOUGHT IN CONNECTION WITH PAST OR IMPENDING JOB LOSSES AT OTHER FACILITIES?**
   YES: _____ IF YES, PLEASE EXPLAIN: _____
   NO: _____

7. **IF LOSSES ARE INDICATED DATE WHICH, AT A MINIMUM IS, 120 DAYS FROM DATE NOTED IN ITEM #5.**

8. **IS THE BUSINESS CURRENTLY COVERED FOR UNEMPLOYMENT INSURANCE COMPENSATION AND WORKER'S COMPENSATON?**
   YES: _____ NO: _____ IF NO, PLEASE EXPLAIN:_____

9. **WILL THE RATE OF REIMBURSEMENT BE MORE THAN 50%? YES:_____ NO:_____**
   IF YES, EXPLAIN WHAT RATE WILL BE PAID AND THE JUSTIFICATION FOR THE HIGHER RATE:_____

   _____

10. **IS EMPLOYER ELIGIBLE FOR OJT: YES:_____ NO: _____**

11. **I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT I AGREE WITH THE FINDINGS OF THIS OJT PRE-AWARD REVIEW.**

_____ _____

SIGNATURE OF STAFF/DATE **SIGNATURE OF EMPLOYER**