WIOA Work Experience Incident Report

WIOA Worksite Agreement Number: _____

Worksite Supervisor: Please complete the following information and submit it to the WIOA Grantee and/or Service Provider immediately.

Worksite Information

Worksite: _____
Worksite Address: _____
Worksite Telephone: _____
Worksite Supervisor: _____
Supervisor Telephone Number: _____
Alternate Supervisor (if applicable): _____
Alternate Supervisor Telephone: _____

TRAINEE INFORMATION

Trainee Name: _____
Participant ID (if known): _____
Trainee Telephone: _____
Trainee Address: _____
City: _____
Zip Code: _____

INCIDENT INFORMATION

Date of Incident: _____
Time of Incident: _____
Location of Incident: _____
City: _____
Zip Code: _____
Description of Incident (include how, where, and circumstances):

Was medical treatment required? ◯ Yes ◯ No If yes:
Physician Name: _____
Physician Address: _____
City: _____
Zip Code: _____

COMPLETE THIS SECTION ONLY IF INCIDENT WAS REPORTED TO POLICE

Police Station Name/Number: _____
Officer Name: _____
Officer Telephone: _____

CERTIFICATION

I certify that the above information is true and accurate to the best of my knowledge.

Worksite Supervisor Signature: _____ **Trainee Signature:** _____
Date: _____ **Date:** _____

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Employer Contact Consent Form

During orientation, you were informed that we would be contacting those who participated in our education or training program to find out how you are progressing after completing the program. We would like to know if our program helped you achieve your goal of entering postsecondary education/training or obtaining/maintaining employment.

This document provides your consent to contact your employer to obtain information that will be used to evaluate our program services.

I Agree to the Following:

1. I understand that this document provides permission for my employer to be contacted by program staff and that my employer may provide information including my status of employment, length of employment, type of employment, hours of employment, and my hourly/weekly wage during the previous 3-months.
2. I understand that this document only provides permission to contact my employer two times for supplemental information. The first contact will be on/around the 2nd quarter after exit and the second contact will be on/around the 4th quarter after exit.
3. I understand that participation in the supplemental information follow-up is voluntary. My employer can refuse to answer any questions they do not wish to answer.
4. I understand that I have the right to revoke (cancel) the permission I have given to contact my employer at any time by contacting the program and providing written notice. I understand that if I revoke (cancel) permission to contact my employer, information that has already been collected at the time permission is revoked (canceled) will be used in evaluation of program performance; however, further contact to my employer will not be made.
5. I understand that the information gathered will remain confidential.
6. I understand that the information gathered from my employer will only be used to evaluate program performance.

I have read the information, or it has been read to me. I have had the opportunity to ask questions about it, and any questions I have asked have been answered to my satisfaction. I voluntarily consent to employer contact for supplemental information collection if I am unable to be reached.

Participant		**Program Staff**	
Participant ID #:	_____	**Printed Name:**	_____
Printed Name:	_____	**Signature:**	_____
Signature:	_____	**Date:**	_____
Date:	_____		

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