

ELIGIBLE TRAINING PROVIDER/PROGRAM PERFORMANCE

Re-certification 2019-2020

SOUTH CENTRAL WORKFORCE DEVELOPMENT BOARD

Provider Name:

Provider Contact: _____

Phone: _____ **Email:** _____

I. Updated Program Information or Revised Costs (please describe below):

II. Please provide the following information by program for each of the outcomes listed below. Data will be validated annually through reports from the Virginia Workforce Connection.

A. Training Completion Rate (must meet or exceed 50%):

Program	# Enrolled in Training	# Successful Completers	Training Completion Rate (%)

D. Post Training Earnings: The reported earnings will be reported as the median earning for those employed in the 2nd quarter after exit. Please provide the earnings using the Number Employed at Completion of Training (in III. above) and listing each wage in increasing order (by amount of wage) and the number of persons earning that amount.

COMMONWEALTH OF VIRGINIA
ANNUAL REVIEW MONITORING TOOL
Eligible Training Provider

Date: _____ Contact's Name: _____ Title: _____
Training Provider's Name: _____
Training Provider's Address _____

Equal Opportunity Policy Adherence:

1. Do you have a grievance procedure, which includes discrimination complaints? Yes No
If no, please describe how discrimination complaints would be handled.
2. Do you have the Equal Opportunity is the Law poster prominently displayed? Yes No
a. If you do have the Equal Opportunity is the Law poster prominently displayed, where is it located?
3. Do you have a policy for serving students with disabilities? (provide a copy) Yes No
If no, please describe how you would ensure that students with disabilities would have equal access to training programs.
4. Do you have a policy for serving students with limited English proficiency? Yes No
(provide a copy) If no, please describe how you would ensure that individuals with limited English proficiency would have equal access to training programs.
5. Do you ensure that training is provided in the most accessible setting? Yes No

Signature _____

Date _____

Equal Opportunity Employer/Program. Auxiliary Aids and services available upon request to individual with disabilities.