



## Eligible Training Provider Assurances Form

Please e-mail a PDF of this form to Barbara Mix at [barbara.mix@wtb.wa.gov](mailto:barbara.mix@wtb.wa.gov)

Or mail to:

Barbara Mix

Workforce Training and Education Coordinating Board

PO Box 43105

Olympia, WA 98504-3105

### Part A.

I certify that \_\_\_\_\_ (name of school/organization):

- (a) is a legal entity, registered to do business in Washington state,
- (b) has not been determined to be ineligible to receive Federal funds,
- (c) does not discriminate against nor deny employment or services to any person on the grounds of race, color, religion, sex, national origin, age, handicap, citizenship, political affiliation or belief,
- (d) complies with the 1990 Americans with Disabilities Act (ADA),
- (e) has demonstrated effectiveness in operating occupational classroom or distance training programs(s),
- (f) agrees that provider facilities, classroom instruction, relevant financial records, and attendance records may be reviewed during the period of performance of any voucher by state, federal and/or local monitors or auditors to ensure compliance with funding requirements.

### Part B.

I certify that I:

- (a) have reviewed the annual student data reporting requirements established for eligible training providers posted at: <http://www.careerbridge.wa.gov/Page.aspx?nid=80>,
- (b) will report to the Workforce Training and Education Coordinating Board required student records for *all students* trained in each of my school/organization's training programs listed as approved for the Eligible Training Provider List on <http://www.careerbridge.wa.gov>,
- (c) will begin collecting required student data elements that are not currently being collected, and
- (d) will submit the annual student data report by the next due date.

Finally, I understand that the Workforce Training and Education Coordinating Board will not process my school/organization's application for Eligible Training Provider program approval without receiving this Assurances Form.

\_\_\_\_\_ Name of Training Provider (school/organization)

\_\_\_\_\_ Mailing Address

\_\_\_\_\_ City, State, Zip

\_\_\_\_\_ Phone

\_\_\_\_\_ Print Name of School/Organization Representative

\_\_\_\_\_ Title of School/Organization Representative

\_\_\_\_\_ Signature \_\_\_\_\_ Date