1. Name of participant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. PID

**Employer Information**

3. Name of employer

4. Employer mailing address

a. Number and street, suite number; and/or PO Box

b. City

c. State d. ZIP code

5. FEIN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Employer type

 [ ]  Not-for-profit [ ]  For-profit

 [ ]  Government [ ]  Self-employment

7. Is employer a host agency? [ ]  Yes [ ]  No

8. Did employer provide an OJE training site for this participant? [ ]  Yes [ ]  No

9. Employment site name and location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9a. \* Date for next customer satisfaction survey for this employer \_\_\_\_\_\_\_\_\_

9b. Employer continued availability [ ]  Available [ ]  Not available

\*No data entry in SPARQ. Field is system-generated.

This reporting requirement is approved under the Paperwork Reduction Act of 1995, OMB Control No. 1205-0040. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number. Public reporting burden for this collection of information required to obtain or retain benefits (PL 109-365 Sec 501-518) is estimated to average six (6) minutes per response; including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workforce Investment, Room C-4510, 200 Constitution Avenue, NW, Washington, DC 20210 (PRA Project 1205-0040).

**Contact/Supervisor Information**

10. Name of contact person

11. Contact person’s mailing address if different from number 4

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

a. Organization name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Number and Street, Suite Number; and/or PO Box

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. City

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. State e. ZIP Code

12. Contact person’s title

12a. Contact person’s salutation [ ]  Mr. [ ]  Ms. [ ]  Dr.

13. Contact person’s phone number

13a. Contact person’s fax number

13a1. Contact person’s cell phone number

13b. Contact person’s e-mail address

**Complete fields 13c-13i if supervisor is different from contact person (number 10). If supervisor is the same as contact person, skip to field 14.**

13c. Name of supervisor

13d. Supervisor’s mailing address if different from number 4

a. Organization name

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 b. Number and Street, Suite Number; or PO Box

c. City

d. State e. Zip Code

13e. Supervisor’s title

13f. Supervisor’s salutation [ ]  Mr. [ ]  Ms. [ ]  Dr.

13g. Supervisor’s phone number

13h. Supervisor’s fax number

13h1. Supervisor’s cell phone number

13i. Supervisor’s e-mail address

**Placement Information**

14. Start date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MM/DD/YYYY)

15. End date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MM/DD/YYYY)

16. Starting wage per hour $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Benefits (check all that apply)

|  |  |  |
| --- | --- | --- |
| [ ]  a. Health insurance | [ ]  d. Vacation | [ ]  g. Other\_\_\_\_\_\_\_\_\_\_(specify) |
| [ ]  b. Sick leave | [ ]  e. Transportation | [ ]  h. None |
| [ ]  c. Pension/profit sharing | [ ]  f. Room and board |  |

18. At time of placement, is employment expected to be full- or part-time?

 [ ]  Full-time [ ]  Part-time

If part-time, number of hours per week expected

19. Job title

19a. Participant’s job code \_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| 1. Art, Design, Entertainment, Sports, and Media | 8. Food Preparation and Service | 15. Production, Assembly, Light Industrial |
| 2. Business and Financial Operations | 9. Healthcare | 16. Protective Service |
| 3. Community and Social Services | 10. Legal | 17. Retail, Sales, and Related |
| 4. Computer and Mathematical | 11. Maintenance and Custodial | 18. Self-Employment |
| 5. Construction, Installation, and Repair | 12. Management | 19. Transportation and Material Moving |
| 6. Education, Training, and Library | 13. Office and Administrative Support |  |
| 7. Farming, Fishing, and Forestry | 14. Personal Care and Service |  |

19b. High-growth placement

|  |  |  |
| --- | --- | --- |
| [ ]  1. Automotive | [ ]  6. Financial Services  | [ ]  11. Retail  |
| [ ]  2. Advanced Manufacturing  | [ ]  7. Geospatial | [ ]  12. Transportation  |
| [ ]  3. Biotechnology[ ]  4. Construction[ ]  5. Energy | [ ]  8. Health Care [ ]  9. Hospitality [ ]  10. Information Technology  | [ ]  13. None |

20. Training-related placement? [ ]  Yes [ ]  No

21. Was placement the result of a substantial service provided to the employer by the sub-grantee? [ ]  Yes [ ]  No

21a. Type of supportive service provided:

|  |  |
| --- | --- |
| [ ]  i. Dependent care (child or adult) | [ ]  v. Needs-related payments, such as utilities or food |
| [ ]  ii. Health and medical services | [ ]  vi. Special job-related or personal counseling |
| [ ]  iii. Housing, including temporary shelter | [ ]  vii. Transportation |
| [ ]  iv. Incidentals such as work shoes, badges, uniforms, eyeglasses, and tools | [ ]  viii. Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

21b. Date supportive service provided\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

21c. Supportive service provided by:

|  |
| --- |
| [ ]  i. Grantee or sub-recipient/local project |
| [ ]  ii. Workforce partner[ ]  iii. Both i and ii |
| [ ]  iv. Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

22. Unsubsidized employment comments

**Customer Service Survey Information**

23. CS survey number 1\_\_\_\_\_\_\_\_\_\_\_Date of delivery\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

24. CS survey number 2\_\_\_\_\_\_\_\_\_\_\_Date of delivery\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

25. CS survey number 3\_\_\_\_\_\_\_\_\_\_\_Date of delivery\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

**Follow-up Information**

26. \*90-day date (MM/DD/YYYY)

27. Has the participant returned to program within the first 90 days after exit?

 [ ]  Yes [ ]  No

27a. Has the participant re-enrolled in SCSEP within the first 90 days after exit?

 [ ]  Yes [ ]  No

28. Follow-up 1

a. \*Scheduled date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

b. Completed date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MM/DD/YYYY)

c. Any wages for first quarter after exit quarter? Please also indicate method of verification

* + 1. [ ]  No wages

 vi. [ ]  Yes, supplemental through case management, participant survey, and/or verification

with the employer

 vii. [ ]  Unable to obtain information

 viii. [ ]  Excluded

c1. If excluded, reason

1. [ ]  Deceased
2. [ ]  Health/medical
3. [ ]  Family care
4. [ ]  Institutionalized

29. Follow-up 2

* 1. \*Scheduled date (MM/DD/YYYY)
	2. Completed date (MM/DD/YYYY)
	3. Any wages for second quarter after exit quarter? Please also indicate method of verification

 i. [ ]  No wages

 vi. [ ]  Yes, supplemental through case management, participant survey, and/or verification

with the employer

 vii. [ ]  Unable to obtain information

 viii. [ ]  Excluded

c1. If excluded, reason

1. [ ]  Deceased
2. [ ]  Health/medical
3. [ ]  Family care
4. [ ]  Institutionalized
	1. If yes, earnings for second quarter after exit quarter $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Any wages for third quarter after exit quarter? Please also indicate method of verification

 i. [ ]  No wages

 vi. [ ]  Yes, supplemental through case management, participant survey, and/or verification

with the employer

 vii. [ ]  Unable to obtain information

 viii. [ ]  Excluded

e1. If excluded, reason

1. [ ]  Deceased
2. [ ]  Health/medical
3. [ ]  Family care
4. [ ]  Institutionalized
	1. If yes, earnings for third quarter after exit quarter $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

30. Follow-up 3

a. \*Scheduled date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

b. Completed date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

c. Any wages for fourth quarter after exit quarter? Please also indicate method of verification

 i. [ ]  No wages

 vi. [ ]  Yes, supplemental through case management, participant survey, and/or verification

with the employer

 vii. [ ]  Unable to obtain information

 viii. [ ]  Excluded

c1. If excluded, reason

1. [ ]  Deceased
2. [ ]  Health/medical
3. [ ]  Family care
4. [ ]  Institutionalized

31. Customer satisfaction and follow-up comments.

\*No data entry in SPARQ. Field is system-generated.