



Quick Response Training

Sample Application

This is a sample application to prepare you for the [online application](#). Before submitting your online application, be sure that all sections are completed, and all document are uploaded. Failure to submit all documents with your application will delay processing of your application.

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Section 1

Employer Information

Company: *

Company Name:	Street/Mailing Address:
City:	State:
Postal Code:	County:

Enter your parent company information (If applicable):

Parent Company Name:

Street:	City:
State:	Postal Code:

Is this the address of the expansion/relocation? *Choose one. **

Yes	No
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Is this company minority-owned? *Choose one. **

Yes	No
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Detailed description of your business including industry information, history of business and projections of company: *

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Legal structure of your business: *Choose one. **

Legal Structure	Sole Proprietor
Sole Proprietor	Partnership
Corporation	Non-Profit
Leased	Other

If "other", specify:

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Company Information

Enter your company information:

*Employer's FEIN # (9 digits):	Unemployment Comp ID #:
Florida sales tax registration #:	Registration # (13 digits):

Enter your NAICS code: *You may search for your NAICS code at siccode.com or the U.S. Census Bureau. **

Primary NAICS Code (6 digits):	Secondary NAICS (required if applicable):
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Contact person responsible for application completion: *

Full Name	
Title	Phone
Fax	
Email Address	
Business Website Address	

Will the business be expanding or locating in a rural area, brownfield area, or urban/distressed? *

Yes	No
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Is the training sought for: *Choose one. ** (Note: There are legal restrictions related to funds for relocation. Please contact the FloridaFlex staff for specifics).

New Florida business	Relocation from one Florida community to another
Expansion of Existing Florida Business	

Is this a headquarters project? *

Yes	No
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Number of employees at this site: *

Number of full-time employees: *

Number of part-time employees:

Number of temporary employees:

Number of leased (staffing agency) employees:

Does the company provide benefits for all full-time employees? *

Yes	No
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If "yes", specify: Choose one.

Health Insurance	Vacation
Dental Insurance	Sick Leave
Vision	Other

Number of hours worked per week: *

Capital investment amount: *

 \$

Number of new full-time jobs to be created within the next 12 months that are permanent, full-time employees and to be trained through this application: *

Requirements of potential employees (drug testing, hazardous materials, varied shifts, hours worked per week) Select:

Drug Testing	Varied Shifts
Hazardous Materials	None

Has the business ever been subjected to criminal or civil fines and penalties? *

Yes	No
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If "yes", please explain:

Has the business received previous training services from the State of Florida, give types and dates: *

Yes	No
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If "yes", please describe:

Has the business received local or state financial support? *

Yes	No
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If "yes", please describe. Give type(s), amount(s), and date(s):

Give any comments relative to application consideration, (These may include importance of the employer to the industry base of the community; location in a distressed urban or rural area, Brownfield area; workforce diversity; in-kind/cash matches; quality and wages of jobs create; technical difficulty of training, etc.). **Also describe the business, business history, and nature of business:**

How did you learn about the FloridaFlex training program? *

In compliance with F.S. 288.078, do you request confidentiality? *

Yes	No
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By typing my name in the signature box, below, I certify that to the best of my knowledge the information included in this application is accurate.

Authorized First Name: *

Authorized Last Name: *

Title of Authorized Officer:

E-mail: *

Date: *

Please provide the name, title and contact information of the company personnel who will be responsible for processing the required monthly reports and payment reimbursement requests. *

First Name:	Last Name:
Title:	
Street Address:	
City:	State:
Zip Code:	Phone Number:
E-mail Address:	

Section 2

Fiscal Agent

Select State Fiscal Agent:

Section 2a

Position Information

Job Title: *

Number of New Hires: *

Please enter the Annual wage (For example: If the wage is \$21.00/hr *2080 = Annual Wage.)

Starting Annual Wage: *

Average Wage: *

Job Description: *

(Please select "Yes" to add more positions)

Are you missing Job Titles?

Yes	No
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Section 3

Training Summary

Name of training provider: *

Training provider address: *

Street:	City:
State:	Postal Code:

Training provider website: *

Training contact person information: *

Full Name:	Title:
Phone:	Fax:
Email:	

Training start date:

Training end date:

Location of training: *

Provide Courses titles and a description of each: *

General overall objectives of training program: *

Type of training provider: Choose one. *

Public Training Institution (College or University)	Private Training Institution
Company Employee	Private Instructor

Training will be delivered: Choose one. *

On-Site
At the Training Institution
At a Remote Location

Section 4

Training Program Budget – Actual Cost

Note: QRT funds cannot be used to reimburse any training costs occurring before the grant is approved. Please consider this when developing your budget and timeline.

Number of trainees: *

Instructor wages: (Breakout costs for individual programs including total hours and instructor wages and attach worksheet identifying total) **Example:** Should be the total cost of the training 1) How to make Plastic \$500 x (5) = \$2500. 2) New Visions \$35/hr x 24 hrs = \$840 TOTAL COSTS = \$3,340*

Curriculum development cost (Break out costs for individual course requiring development): *

Manuals/Textbooks (Itemize. **Example:** Should be the total cost of the manuals. (10) New Vision Manuals @\$30 each = \$300): *

Training facility usage: This is a **required field** if some training takes place at company site

Training equipment purchase/usage: Must be employer contribution. *

Travel, food and/or lodging: This is a **required field** if some training takes place off site

Other costs total dollar amount: (i.e. copies, DVD's, etc.)

Total Cost:

Trainee wages: (Training Wages = Total of all wages paid to the trainees during the training period) *

Indirect Cost:

Section 5

Certification by Authorized Company Representative

Notice of confidential of Information

To the extent feasible and permissible by law, CareerSource Florida, Inc. (CSF) will honor an applicant's request that confidential information submitted to CSF will remain confidential. CSF will treat the information confidential only if: (i) the information is in fact protected confidential information such as trade secrets or privileged or confidential commercial or financial information, (ii) the information is specifically marked and identified as confidential by the applicant, (iii) the information is segregated and placed in a separate appendix to the application, and (iv) no disclosure of the information is required by law or judicial order. If the application results in a grant, the honoring of the confidentiality of identified data shall not limit CSF's right to disclose the details and results of this award to the public.

MANAGEMENT CERTIFICATION

I hereby certify that I have read the foregoing application and that the information contained herein is true and accurate to the best of my knowledge and belief. Furthermore, to the best of my knowledge and belief, our company and/or organization does not have any outstanding liabilities to the State of Florida. I am aware that any false information or intended omissions may subject me to civil or criminal penalties for filing of false public records and/or forfeiture of any training award approved through this program.

TERMS, CONDITIONS & ASSURANCES CERTIFICATION

I hereby certify that I have read the terms, conditions and assurances posted on the CareerSource Florida, Inc. web site, and if awarded an QRT Grant, I certify and hereby agree that our company and or/organization will abide by them for the term of the grant period.

By typing my name in the signature box, below, I certify I have authority to enter into contracts on behalf of the applying company. *Signature of Authorized Contact **

First Name:	Last Name:
Title:	
Email Address:	
Phone Number:	Ext:
Date Signed:	

Application Prepared By: (if different from authorized company representative, above)

Name:	
Title:	
Company:	
Email Address:	
Phone Number:	Ext:

Authorized Company Address

Street:
City:
State:
Zip:

The authorized company representative would like to have another party be included in correspondence relating to the application.

Authorized another party

Yes	No
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EDO Letter.

Submit letter(s) of endorsement from the authorized local economic development organization(s) addressed to CareerSource Florida. Your fiscal agent will assist.

Fiscal Agent Letter.

Submit letter(s) from local educational entity certifying that courses are not available at the local level. (Submitted by your fiscal agent.)

Local CareerSource (LWDB) Letter.

Submit letter from local CareerSource Florida acknowledging assistance offered and describing services available to business. Your fiscal agent will assist.

Letter from business.

Letter from business to CareerSource Florida requesting training funds.

Certification of Completion

Business name as it would appear on contract: *

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Name of individual certifying application completion:

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E-mail:

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I certify all sections of the Incumbent Worker Training application have been completed and all required documentation has been uploaded: Choose one.

Yes	No
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