

Orientation Check off List

Student: _____

Date: _____

_____ Referral form from ESS Worker (109CIV)

_____ Employment & Income Verification (TAD104)

_____ Orientation Sign off Sheet (TFF01)

_____ Unemployment Insurance is *not* available to me (TFF02)

_____ Equal Opportunity (TFF03)

_____ Emergency Contacts (TFF04)

_____ Complaint and Grievance (HS39)

_____ W-4 with Copy of Photo Id and Copy of Social Security Card

_____ I-9

_____ 1st Case Note (TFF05)

In the Case Note please specify:

- Program the custom was refer to with dates and time they will be attending and who the training facility will be
- What city they reside in for job development consideration
- Any barriers they are facing in attending this training or Work experience
- Preferred method of contact with contact information

Worker Name: _____

Worker ID: _____

Worker Phone Number: _____

Date: _____

Case Name: _____

Case Number: _____

Referral To Activity

Customer Information

Name: _____

Social Security Number: _____

Contact Number: _____

Primary Language: _____

Goals: _____

Test Scores: Math _____ Reading _____

Enroll participant in the following activity.

Remove participant from the following activity.

Activity Name: _____

Activity Number: _____

Days Per Week: _____

Hours: From _____ To _____

Start Date: _____

Expected End Date: _____

Comments: _____

Provider Information

Name: _____

Phone: _____

Address: _____

Fax: _____

Contact Person: _____

Contract Number: _____

TO BE COMPLETED BY PROVIDER

Participant:	Accepted:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If not accepted, please explain:			
Training Site:	Contact Person:		
	Phone:	()	
	Fax:	()	
	E-mail:		
Authorized Provider Signature:			Date:

FOR COUNTY USE ONLY

Employment Services Worker:	Worker ID:	
Authorized Signature:	Date:	
If Required: Supervisor Signature:	Date:	

CAREER INSTITUTE

Specializing in Career, Education and Life Planning

Orientation Sign Off Sheet

Name: _____

Email Address: _____

Mailing Address: _____
City State Zip

Home phone number: _____ Cell number: _____

1. I understand where and when the training program will be held. ____ Yes ____ No
2. I will attend all the classes, be on time and present myself in a professional manner.
3. If I have attendance issues I will contact my Career Mentor _____ at _____ within a 2 hour period to inform them of the concern. If they are not available I will contact Teresa Taylor at 909-481-0270.
4. Excessive attendance issues will jeopardize your participation in the program.
5. Upon successful completion of the training program, I will be able to work 100 hours of work experience and will be paid at \$9.00 per hour.
6. This work experience will be monitored and the work place supervisor will evaluate my participation. If I receive negative comments about my work I will have the opportunity to correct the concerns but if they are not corrected I will be removed from the work site and the training will be completed.
7. If I feel I am being discriminated against or have a complaint, I will inform my Career Mentor.
8. I will complete a career portfolio after the completion of my training program to assist in the job search process.
9. What kind of skills and abilities could you bring to a job?
10. Do you have any previous work experience?
11. Do you have transportation? Bus _____ Car _____
12. If you have children, do you made arrangements for childcare?

My signature below acknowledges that I have been explained the program.

Signature

Date

Employment & Income Verification

Date: _____

Worker Name: _____

Worker ID: _____

Worker Phone Number: _____

Case Name: _____

Case Number: _____

To be completed by TANF participant:

I have read or had read to me this document. This release is valid for one (1) year from the date signed unless I choose to revoke it. I hereby authorize my employer to release the following information to the County:

Applicant/recipient's Signature: _____ Date: _____

Please provide the following information regarding _____ SSN: _____
Employee's Name (print legibly)

To be completed by Career Institute:

Currently Employed **Yes** **No** If no, last day of work _____ Reason for leaving _____

Payment is issued:

Weekly Bi-Weekly Day of Week: _____

Monthly Semi-Monthly Day of Month: _____

Paid by: Check Cash Draft Direct Deposit

Deductions Taken:

Health Insurance - \$ _____/pay period
 (This is not an eligible deduction for Child Care.)

Court Ordered Child Support - \$ _____/pay period
 (Child Support can be a deduction allowed in Child Care.)

Will employee earn any tips, commission or overtime? Yes No

Indicate below employee's work schedule. State days per week, hours and hours per day. If varied or rotating schedule list current weeks schedule.

Days Worked	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours Worked Per Day	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM
	To _____	To _____	To _____	To _____	To _____	To _____	To _____
	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM

Period End Date	Date Paid	# Hrs Worked	\$ Per Hr	Gross Wages	Period End Date	Date Paid	# Hrs Worked	\$ Per Hr	Gross Wages

Maximum hours per week ____ Minimum hours per week ____ The Employee's Schedule is: Set Variable Rotating

Date of Hire _____ Start Date _____ Rate of pay \$ _____ Per Hour Day Week Month

If on leave of absence, date to return to work _____

Company Name: **Career Institute** Company Address: 10722 Arrow Route Suite 808, Rancho Cucamonga, CA 91730

Phone: (909) 481-0270 Fax: (909) 481-3947 Date: _____

Signature: _____ Title: _____

CAREER INSTITUTE

Specializing in Career, Education and Life Planning

I understand that I may not apply for
Unemployment Insurance

Participant Name: _____

Social Security Number: _____

Date: _____

I understand that I am may not apply for Unemployment Insurance once I have completed my paid training experience.

This is because I am participating in a paid Training Experience Program funded by the County of San Bernardino Human Services who receives federal funds.

I am doing a work experience to gain work experience and maturity in the job market and have not been hired as an employee.

Please use section code 634.5, section E1 for determination purposes.

Participant Signature: _____

EQUAL OPPORTUNITY IS THE LAW

It is against the law for this recipient of Federal financial assistance to discriminate on the following bases:

- Against any individual in the United States, on the basis of race, color, religion, sex, national origin, age, disability, political affiliation or belief; and
- Against any beneficiary of programs financially assisted under Title I of the Workforce Investment Act of 1998 (WIA), on the basis of the beneficiary's citizenship/status as a lawfully admitted immigrant authorized to work in the United States, or his or her participation in any WIA Title I-financially assisted program or activity.

The recipient must not discriminate in any of the following areas:

- Deciding who will be admitted, or have access, to any WIA Title I-financially assisted program or activity;
- Providing opportunities in, or treating any person with regard to, such a program or activity; or
- Making employment decisions in the administration of, or in connection with, such a program or activity.

What To Do If You Believe You Have Experienced Discrimination

If you think that you have been subjected to discrimination under a WIA Title I-financially assisted program or activity, you may file a complaint within 180 days from the date of the alleged violation with either:

- The recipient's Equal Opportunity Officer (or the person whom the recipient has designated for this purpose); or
- The Director, Civil Rights Center (CRC), U.S. Department of Labor, 200 Constitution Avenue NW, Room N-4123, Washington, DC 20210.

If you file your complaint with the recipient, you must wait either until the recipient issues a written Notice of Final Action, or until 90 days have passed (whichever is sooner), before filing with the Civil Rights Center (see address above).

If the recipient does not give you a written Notice of Final Action within 90 days of the day on which you filed your complaint, you do not have to wait for the recipient to issue that Notice before filing a complaint with CRC. However, you must file your CRC complaint within 30 days of the 90-day deadline (in other words, within 120 days after the day on which you filed your complaint with the recipient).

If the recipient does give you a written Notice of Final Action on your complaint, but you are dissatisfied with the decision or resolution, you may file a complaint with CRC. You must file your CRC complaint within 30 days of the date on which you received the Notice of Final Action.

I have read the above and understand my equal opportunity rights under the Workforce Investment Act.

Customer's printed name _____

Customer's signature _____ Date _____

FOR INFORMATION OR TO FILE A COMPLAINT WITH THE RECIPIENT, CONTACT:

Teresa Taylor, CEO
Career Institute
10722 Arrow Route #808 Rancho Cucamonga, CA 91730
Office Phone: (909) 481-0270
Cell Number: (909) 731-8238
FAX: (909) 481-3947
ttaylor@cinow.org

This WIA Title-I financially assisted program or activity is an equal opportunity employer/ program. Auxiliary aids and services are available upon request to individuals with disabilities.

Emergency Contacts

If I'm injured on the training program, I am providing this information to assist the Career Institute Staff to contact my emergency contacts.

.....
Doctor: _____ Phone #: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship: _____

Complete Address: _____

Telephone #: _____

Name: _____ Relationship: _____

Complete Address: _____

Telephone #: _____

COMPLAINT AND GRIEVANCE PROCEDURE

INSTRUCTIONS: THE CUSTOMER IS TO READ AND RECEIVE THE TOP PORTION OF THIS FORM. THE BOTTOM PORTION OF THE FORM IS TO BE SIGNED BY SERVICE RECIPIENT AND PLACED IN THE CONTRACTOR'S RECORDS.

If you believe you have been discriminated against, or that there has been a violation of any laws or regulations, or if you have a problem regarding services received, you have the right to file a complaint or tell us your grievance.

The following procedures are to be followed when filing a complaint or grievance.

STEP ONE:

Write down your complaint or grievance and talk to the service provider. Keep a copy for yourself and write down the date you talked to the service provider.

- If answered or resolved at this step, nothing further is required.
- If no answer or resolution within 10 calendar days, proceed with Step Two.

STEP TWO:

Send a copy of your written complaint or grievance, or discuss the complaint or grievance with your County Caseworker. Write down the date you spoke to your Caseworker or send the complaint and keep it with your copy.

- If answered or resolved at this step, nothing further is required.
- If no answer or resolution within 10 calendar days, proceed with Step Three.

STEP THREE:

Send a copy of your written complaint or grievance to the Program Specialist. If you would like a response, include your name, address and telephone number. Your personal information and your complaint and grievance details will be kept confidential.

HS Program Development Division, Contracts Support Unit
ATTN: Program Specialist
825 E. Hospitality Lane, 2nd Floor
San Bernardino, CA 92415-0079

- If answered or resolved at this step, nothing further is required.
- If no answer or resolution within 10 calendar days, proceed with Step Four.

STEP FOUR:

Send a copy of your written complaint or grievance to the Contract Analyst at:

HS Administrative Support Division
ATTN: Contracts Unit
150 S. Lena Road
San Bernardino, CA 92415-0515

You will be contacted within 10 calendar days if you have provided contact information.

Please note: Each of these steps must be completed in the sequence shown.

..... Detach here

COMPLAINT AND GRIEVANCE PROCEDURE CERTIFICATION

This certifies I have read, understood, and received the Complaint and Grievance Procedures.

Client Signature

Date

PROCEDIMIENTO DE QUEJAS

INSTRUCCIONES: EL CLIENTE TIENE QUE LEER Y RECIBIR LA PARTE DE ARRIBA DE ESTA HOJA. LA PARTE DE ABAJO DE ESTA PÁGINA TIENE QUE SER FIRMADA POR LA PERSONA QUE RECIBE LOS SERVICIOS Y GUARDADA CON LOS ARCHIVOS DEL CONTRATISTA.

Si usted piensa que fue discriminado, u ocurrió una violación de cualquier ley o regulación, o si tiene un problema con los servicios que está recibiendo, usted tiene el derecho de hacer una denuncia o decirnos sus quejas.

Tiene que seguir los siguientes procedimientos para presentar su queja.

PRIMER PASO:

Presente su queja por escrito y hable con el proveedor de servicios. Haga una copia del escrito para usted y escriba la fecha en la que habló con el proveedor de servicios.

- Si en este paso recibió respuesta o resolvió el problema, no tiene que hacer nada más.
- Si no soluciona el problema en 10 días consecutivos, siga al Segundo Paso.

SEGUNDO PASO:

Mande una copia de su queja escrita, o hable con su Trabajador de Caso del Condado sobre su queja. Escriba la fecha en la que habló o envió su queja a su Trabajador de Caso y manténgalo en sus archivos.

- Si en este paso recibió respuesta o resolvió el problema, no tiene que hacer nada más.
- Si no soluciona el problema en 10 días consecutivos, siga al Tercer Paso.

TERCER PASO:

Mande una copia de su queja escrita al especialista de programa. Si quiere una respuesta por favor incluya su nombre, dirección y número de teléfono. Su información personal y los detalles de su queja será confidencial.

HS Program Development Division, Contracts Support Unit
ATTN: Program Specialist
825 E. Hospitality Lane, 2nd Floor
San Bernardino, CA 92415-0079

- Si en este paso recibió respuesta o resolvió el problema, no tiene que hacer nada más.
- Si no soluciona el problema en 10 días consecutivos, siga al Cuarto Paso.

CUARTO PASO:

Mande una copia de su queja escrita al Analista de Contratos a:

HS Administrative Support Division
ATTN: Contracts Unit
150 S. Lena Road
San Bernardino, CA 92415-0515

Estaremos en comunicación con usted dentro de 10 días si proporcionó su nombre, número de teléfono y dirección.

Por favor note: Cada uno de estos pasos tiene que ser hecho en el orden que se indica.

..... **Corte acá**

CERTIFICACIÓN DEL PROCEDIMIENTO DE QUEJAS

Esto certifica que yo e leído, entiendo, y recibí el Procedimiento de Quejas.

Firma del Cliente

Fecha

Your paycheck will be mailed to this address

Photocopy
Photo Id
HERE

Photocopy
Social Security
card
HERE

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

OMB No. 1545-0074

2011

▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

1 Type or print your first name and middle initial.		Last name		2 Your social security number	
Home address (number and street or rural route)				3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code				4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>	
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)				5	
6 Additional amount, if any, you want withheld from each paycheck				6 \$	
7 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶				7	

Company Name: **Career Institute** Company Address: 10722 Arrow Route Suite 808, Rancho Cucamonga, CA 91730

Phone: (909) 481-0270

Fax: (909) 481-3947

Date: _____

Signature: _____

Title: _____

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen or national of the United States
- A lawful permanent resident (Alien #) A _____
- An alien authorized to work until _____
(Alien # or Admission #) _____

Employee's Signature	Date (month/day/year)
----------------------	-----------------------

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		DL or ID card		Social Security card
Issuing authority: _____		CA DMV		Soc Sec Administration
Document #: _____		_____		- -
Expiration Date (if any): _____		- -		na
Document #: _____		_____		
Expiration Date (if any): _____		_____		

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)
Career Institute 10722 Arrow Rt #808 Rancho Cucamonga, CA 91730		

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
-----------------------------	--

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____	Document #: _____	Expiration Date (if any): _____
-----------------------	-------------------	---------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
--	-----------------------

Complete this section ONLY

Name:
Email Address:
Mailing Address:
Home Phone Number:
Cell Number:

Date	Case Note	Staff

(TFF06)