

Training provider should **NOT** be paid in advance of/ or immediately following training. Following submission of application, course outline of desired training, and after hearing approval, 25% of training costs must be submitted to the Northern Tier. Upon completion of training, Northern Tier will fully reimburse the training provider.

Date Received: \_\_\_\_\_

**APPLICATION FOR  
HEALTHCARE WORKER TRAINING GRANT**

<b>Applicant Data</b>	
<b>Company:</b>	
<b>Contact Person:</b>	<b>Contact Person's Title:</b>
<b>Address:</b>	
<b>Phone:</b>	<b>Fax:</b>
<b>Email:</b>	<b>Company Website:</b>

<b>Company Data</b>
<b>Size of Company:</b> <b>#Employees at Location:</b> _____ <b>#Employees Worldwide:</b> _____
<b>Type of Company Ownership:</b>
<b>Union Affiliation:</b>
<b>Location of other Division, Facilities or Headquarters:</b>

<b>Federal Employer Identification Number (FEIN):</b>
<b>Product/Service Description:</b>
<b>Industry Code (NAICS -North American Industry Classification Code):</b>

### **Training Data**

What type of training are you applying for (describe briefly)?
Briefly describe your training needs and explain how funding will assist in achieving company goals.
Identify the training provider(s) or education institution(s) that will provide this training.

<b>Training Participant(s) Name(s) and Social Security Number(s):</b> (required for each individual)			
		<b>OPTIONAL</b>	
1. _____	SS# _____	Gender _____	Race _____
2. _____	SS# _____	Gender _____	Race _____
3. _____	SS# _____	Gender _____	Race _____
4. _____	SS# _____	Gender _____	Race _____
5. _____	SS# _____	Gender _____	Race _____
6. _____	SS# _____	Gender _____	Race _____
7. _____	SS# _____	Gender _____	Race _____
8. _____	SS# _____	Gender _____	Race _____

## Project Data

Projected Start Date: \_\_\_\_\_

Projected Complete Date: \_\_\_\_\_

Total # of employees to be trained: \_\_\_\_\_

Total # of training program hours per day (e.g. 4 hours a day): \_\_\_\_\_

Total # of training days (e.g. 2 days): \_\_\_\_\_

Total Project Cost: \$ \_\_\_\_\_

Certificate obtained upon completion: Yes No  
(circle one)

Date obtained: \_\_\_\_\_

Credential obtained upon completion: Yes No  
(circle one)

Date obtained: \_\_\_\_\_

Proposal Submitted by:

Name: \_\_\_\_\_

Provider: \_\_\_\_\_

Please feel free to include any additional comments/information.

**Please submit (via e-mail or fax) to:**

Deb Mathers - [Mathers@northerntier.org](mailto:Mathers@northerntier.org) or Sherry Felten - [Felten@northerntier.org](mailto:Felten@northerntier.org)

fax to (570) 265-7585

NTRPDC

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