IOWA WORKFORCE DEVELOPMENT

Training Extension Benefits

60-0192 (09-2011)

Print Form

Social Security Number

For Office Use Only

Detection Date:														
O.C. Date						REF		Employer Account Number								
Deputy		ANDS			Variable 1						Variable 2					

Sunday through Saturday

If you fail to fully complete this form, your application will not be processed.

First Name MI

Last Name

My most recent occupation: _____ ☐ Full-Time ☐ Part-Time

Occupational Goal: _____ Occupational Code: | | | - | | | | |

Name of School

Location of School: (Street Address, City, State, Zip Code)

Length of entire training program:

Start Date (Month, Day, Year) | | | | | | |

End of Program Date (Month, Day, Year) | | | | | | |

School Registrar Phone Number: (____)_____

- I understand I must attach the class schedule. **THE APPLICATION IS INCOMPLETE WITHOUT THE CLASS SCHEDULE AND WILL NOT BE APPROVED.**
- I do certify that the statements above are true and made with my knowledge and will be a part of the claim record file. I also understand that any statement made herein may be used as evidence in the determination of eligibility for Training Extension Benefits.
- I understand that I must report my weekly claim by telephone or web reporting in order to be paid by TEB and that as long as I am attending classes, I should indicate that I am able and available each week.
- I understand the maximum amount of training extension benefits is 26 weeks and is only available when all other types of benefits are exhausted. I also understand the **training extension benefits end when my unemployment claim has exceeded the deadline of two years past my original claim date** and I understand this could mean I would **receive less than the 26 week maximum** listed on my decision letter. I understand that if I discontinue or complete training I no longer qualify for the weekly training extension benefits and should discontinue submitting weekly unemployment insurance claims immediately.

Your application and schedule will be reviewed and you will receive an appealable decision in the mail.

Phone: (____)_____ Alt. Phone: (____)_____ E-mail: _____

Claimant Signature: _____ Date Signed: _____

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.
For deaf, and hard of hearing, use Relay 711