# IOWA WORKFORCE DEVELOPMENT

**Application For Department Approved Training**

69-0018 (08-2010)

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*

First Name MI

Last Name

I hereby make application for **Department Approved Training**. I understand that while attending the approved training I will not have to be available for work or actively seeking work, but must be able and available to attend the training.

I do certify that the following statement is true and that it is being made of my own free will, and with my knowledge that it will be made 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 Unemployment Insurance Benefits.

I am / plan on attending:

_____

(Name of School)

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

I will pursue training as:

_____

(Occupation)

The length of the course is from:

_____ to _____

(Month, Day, Year) (Month, Day, Year)

**Note:** You should answer that you are able and available for work each week.

**You must attach the class schedule. THE APPLICATION IS INCOMPLETE WITHOUT THE CLASS SCHEDULE AND WILL NOT BE APPROVED.**

I understand that, **AFTER COMPLETION OF THIS TRAINING OR I QUIT TRAINING,** the following eligibility conditions will apply in order to be eligible for unemployment insurance benefits.

- I must not place any restrictions on my employability.
- I must be able to work, available for work and be searching for work after training.
- I may be subject to disqualification for unemployment insurance benefits for any refusal of work without good cause after completion of training.
- I must make and keep a record of at least 2 work search contacts and provide the information upon request to Iowa Workforce Development.
- I must contact the Workforce Development Center if I complete or quit school.

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**