Career Skills Training Program
Referral Form

Trainee's Name:				Phone:	
Email Address:					
Address:				Msg Phone:	
City:		State**:**		Zip:	
L Number:				Date of birth:	
Skills Training Job Title:					
Physical Limitations/ Disability:					

Training Site:					
Email Address:					
Skills Training Supervisor:					
Address:				Phone:	
City:		State:		Zip:	

Vocational Consultant:					
Email Address:					
Agency:					
Address:				Phone:	
City:		State:		Zip:	

Length of Training:			
From (mm/dd/yyyy):		To (mm/dd/yyyy):	
Are related classes part of the plan?		☐ Yes	☐ No
Monthly incentive to employer?		☐ Yes	☐ No
Insurance carrier:			
Phone:		Claim Number:	

Note: Please attach to this form: (1) Authorized Training Plan; (2) Proposed Skills Training Curriculum; (3) Authorization for Payment (AFP). Thank you!

Mail To: Lane Community College
ATTN: Chuck Fike