RAMSEY COUNTY
Workforce Solutions

TRAINING AGREEMENT/CONSENT TO RELEASE INFORMATION

Name:_____ Date of birth:_____

Training facility: _____ Training program:_____

Client agrees to:

_____ Maintain contact with counselor, minimum of once every 30 days.
_____ Apply for PELL and State grants (if applicable) and apply these funds to tuition and books before accessing Dislocated Worker funds.
_____ Provide copy of fee statement and class schedule before the start of the session.
_____ Provide grades/certificates after the completion of each course. Additional funding will only be approved after these are received.
_____ In an academic program, maintain at least a C average.
_____ Notify counselor of any changes in status – address, phone, change in training plans, change in class schedules, etc.
_____ When employed part time or full time, temporary or permanent, provide job information ASAP including employer, employer's city/state, job title, start date, wage, and benefits

(NOTE: We DO NOT call the employer – this information is needed for statistical purposes and is a requirement for our continued funding.)

The counselor will close the Dislocated Worker file if:

1. The client takes a full-time job in that is longer than 6 months in duration.
2. The client has not remained in monthly contact with the counselor and the counselor is unable to reach the client.
3. The client makes changes to the original plan without counselor approval.

I authorize Ramsey County Workforce Solutions to release information to and request information from

_____ regarding those items checked below:

___ Financial Aid: Grant/Loan
___ Attendance Verification
___ Transcript/Diploma/Degree/Certificates
___ Other _____
___ Assessment results
___ Third Party Payment/Documentation
___ Contact Information (address/phone)

The information is to be used for vocation planning. I understand that my records are protected under the Minnesota Data Practices Act and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by written notice. I understand that my revocation may not be made retroactive and will not apply where action had been taken in reliance upon it (e.g., probation, parole, etc.). This consent automatically expires one year after my file has been exited from the program.

_____ _____ _____
Client Signature *Name (please print)* *Date*

_____ _____
Counselor Signature *Date*

Rev. 1/2017