1. Name of participant___________________    2. PID ________________________________

Employer Information

3. Name of employer _______________________________________________________________

4. Employer mailing address
   a. Number and street, suite number; and/or PO Box
   b. City
   c. State d. ZIP code

5. FEIN_____________________________

6. Employer type
   □ Not-for-profit   □ For-profit
   □ Government     □ Self-employment

7. Is employer a host agency?    □ Yes    □ No

8. Did employer provide an OJE training site for this participant?        □ Yes □ No

   No

9. Employment site name and location___________________________________________

9a. *Employer received customer satisfaction survey in PY ________

9b. Employer continued availability □ Available □ Not available

*No data entry in SPARQ. Field is system-generated.

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(Revised March 2012; replaces prior versions)

This reporting requirement is approved under the Paperwork Reduction Act of 1995, OMB Control No. 1205-0040. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number. Public reporting burden for this collection of information required to obtain or retain benefits (PL 109-365 Sec 501-518) is estimated to average six (6) minutes per response; including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Adult Services, Room S-4203, 200 Constitution Avenue, NW, Washington, DC 20210 (PRA Project 1205-0040).
### Contact/Supervisor Information

10. Name of contact person ____________________________________________________________

11. Contact person’s mailing address if different from number 4
   
   ____________________________________________________________
   
   a. Organization name or address field 1
   
   ____________________________________________________________
   
   b. Number and Street, Suite Number; and/or PO Box or address field 2
   
   ____________________________________________________________
   
   c. City
   
   ____________________________________________________________
   
   d. State                                           e. ZIP Code

12. Contact person’s title ____________________________________________________________

12a. Contact person’s salutation     ☐ Mr.  ☐ Ms.  ☐ Dr.

13. Contact person’s phone number __________________________________________________

13a. Contact person’s fax number __________________________________________________

13a1. Contact person’s cell phone number ____________________________________________

13b. Contact person’s e-mail address ________________________________________________

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Complete fields 13c-13i if supervisor is different from contact person (number 10).

**If supervisor is the same as contact person, skip to field 14.**

13c. Name of supervisor ____________________________________________________________

13d. Supervisor’s mailing address if different from number 4
   
   ____________________________________________________________
   
   a. Organization or address field 1
   
   ____________________________________________________________
   
   b. Number and Street, Suite Number; or PO Box or address field 2
   
   ____________________________________________________________
   
   c. City
   
   ____________________________________________________________
   
   d. State                                           e. ZIP Code

13e. Supervisor’s title ______________________________________________________________

13f. Supervisor’s salutation     ☐ Mr.  ☐ Ms.  ☐ Dr.

13g. Supervisor’s phone number ____________________________________________________
13h. Supervisor’s fax number ___________________________________________

13h1. Supervisor’s cell phone number _____________________________________

13i. Supervisor’s e-mail address ___________________________________________

**Placement Information**

14. Start date_______________________ (MM/DD/YYYY)

15. End date_______________________ (MM/DD/YYYY)

16. Starting wage per hour $_____________________

17. Benefits (check all that apply)
   - [ ] a. Health insurance
   - [ ] b. Sick leave
   - [ ] c. Pension/profit sharing
   - [ ] d. Vacation
   - [ ] e. Transportation
   - [ ] f. Room and board
   - [ ] g. Other_________(specify)
   - [ ] h. None

18. At time of placement, is employment expected to be full- or part-time?
   - [ ] Full-time
   - [ ] Part-time

If part-time, number of hours per week expected_________

19. Job title ___________________________________________________________

19a. Participant’s job code _________

<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>3. Community and Social Services</td>
<td>10. Legal</td>
<td>17. Retail, Sales, and Related</td>
</tr>
<tr>
<td>7. Farming, Fishing, and Forestry</td>
<td>14. Personal Care and Service</td>
<td></td>
</tr>
</tbody>
</table>

19b. High-growth placement
   - [ ] 1. Automotive
   - [ ] 2. Advanced Manufacturing
   - [ ] 3. Biotechnology
   - [ ] 4. Construction
   - [ ] 5. Energy
   - [ ] 6. Financial Services
   - [ ] 7. Geospatial
   - [ ] 8. Health Care
   - [ ] 9. Hospitality
   - [ ] 10. Information Technology
   - [ ] 11. Retail
   - [ ] 12. Transportation
   - [ ] 13. None

20. Training-related placement? [ ] Yes [ ] No
21. Was placement the result of a substantial service provided to the employer by the sub-grantee?  ☐ Yes  ☐ No

22. Unsubsidized employment comments

Customer Service Survey Information

23. CS survey number 1________________ Date __________ (MM/DD/YYYY)
24. CS survey number 2________________ Date __________ (MM/DD/YYYY)
25. CS survey number 3________________ Date __________ (MM/DD/YYYY)

Follow-up Information

26. *90-day date_________________________ (MM/DD/YYYY)

27. Has the participant returned to program within the first 90 days after exit?  ☐ Yes  ☐ No

27a. Has the participant re-enrolled in SCSEP within the first 90 days after exit?  ☐ Yes  ☐ No

28. Follow-up 1
   a. *Scheduled date____________________ (MM/DD/YYYY)
   b. Completed date____________________(MM/DD/YYYY)
   c. Any wages for first quarter after exit quarter? Please also indicate method of verification
      i. ☐ No wages
      vi. ☐ Yes, supplemental through case management, participant survey, and/or verification with the employer
      vii. ☐ Unable to obtain information
      viii. ☐ Excluded
   c1. If excluded, reason
      i. ☐ Deceased
      ii. ☐ Health/medical
      iii. ☐ Family care
      iv. ☐ Institutionalized

29. Follow-up 2
   a. *Scheduled date ______________________(MM/DD/YYYY)
   b. Completed date ______________________(MM/DD/YYYY)
c. Any wages for second quarter after exit quarter? Please also indicate method of verification
   i. No wages
   vi. Yes, supplemental through case management, participant survey, and/or verification with the employer
   vii. Unable to obtain information
   viii. Excluded

c1. If excluded, reason
   i. Deceased
   ii. Health/medical
   iii. Family care
   iv. Institutionalized

d. If yes, earnings for second quarter after exit quarter $________________________

e. Any wages for third quarter after exit quarter? Please also indicate method of verification
   i. No wages
   vi. Yes, supplemental through case management, participant survey, and/or verification with the employer
   vii. Unable to obtain information
   viii. Excluded

e1. If excluded, reason
   i. Deceased
   ii. Health/medical
   iii. Family care
   iv. Institutionalized

f. If yes, earnings for third quarter after exit quarter $________________________

30. Follow-up 3
   a. *Scheduled date___________________ (MM/DD/YYYY)
   b. Completed date _________________ (MM/DD/YYYY)
   c. Any wages for fourth quarter after exit quarter? Please also indicate method of verification
      i. No wages
      vi. Yes, supplemental through case management, participant survey, and/or verification with the employer
      vii. Unable to obtain information
      viii. Excluded
   c1. If excluded, reason
      i. Deceased
      ii. Health/medical
      iii. Family care
      iv. Institutionalized

31. Customer satisfaction and follow-up comments.

   *No data entry in SPARQ. Field is system-generated.