



PO Box 296
Kotzebue, AK 99752
ph (907) 442-3467
fax (907) 442-2162
www.kotzebueira.org

General Assistance Application

Dear General Assistance Applicant:

In order to determine your eligibility for General Assistance you must be Alaska Native or American Indian and enrolled in a Federally Recognized Tribe or have a Certificate of Degree of Indian Blood (CDIB) issued by the Bureau of Indian Affairs. You must live within the Native Village of Kotzebue service area and submit a completed General Assistance application, which includes the following:

- Completed General Assistance Application with all questions/sections answered or filled out properly. If a question or section does not apply to you, write "Not Applicable or N/A". **Applications not filled out properly or entirely will not be processed.**
- Proof of Tribal enrollment or CDIB for all countable household members.
- Government issued photo identification for all countable adult household members.
- Proof of residency in Native Village of Kotzebue service area.
- Proof of ALL INCOME (earned and unearned) which must also include bank statement(s) for all countable household members for the month in which you are applying for assistance.
- If currently employed, provide an Employment Proof form signed by your employer.
- If unemployed provide completed Work Search/Work Related Activity Sheets for each countable employable adult household member.
- Provide copies of your most recent statements/invoices (bills) and receipts showing payments made for all shelter and utility costs that apply to your household. Shelter/Utility bills must be in applicant/spouse's name.
- If you have children, you must provide proof that you have applied for ATAP/TANF and if you are not eligible for ATAP/TANF you must provide proof of denial.
- If applicable, provide proof of guardianship of non-biological children in your custody, (i.e. grandchild, niece/nephew, etc.).
- Birth Certificates for all countable minor dependent children in the household.
- Other documentation to determine eligibility or exemption from General Assistance requirements (i.e., medical, disability, social security status, etc.).

A decision will be made within 30 days of your application date and you will be notified in writing within 45 days of your application date. If you are eligible and employable, you will need to schedule an appointment with me to develop an Individual Self-Sufficiency Plan (ISP) before payment can be made. If you are eligible and unemployable with a verified medical excuse from work/work activity, you will need to schedule an appointment with me to develop a Case Plan before payment can be made.

You will be required to apply for other financial assistance programs – State/Federal/Tribal for which you are eligible. However, please note that if you are already receiving ATAP/TANF, Adult Public Assistance, Disability or any other State, Federal or Tribal financial assistance you may be determined ineligible for General Assistance under the federal regulations.

If you have any questions or concerns regarding the General Assistance application process, please call me at 907-442-3467

Sincerely, Welfare Assistance Case worker

Have you received ATAP or TANF in the last month: Yes No If yes, how much: \$ _____

Has your ATAP/TANF been reduced due to penalties: Yes No Reason: _____

Have you been terminated from ATAP/TANF: Yes No Date of termination: ___/___/___

Have you been determined ineligible for ATAP/TANF: Yes No Reason: _____

Have you been denied ATAP/TANF: Yes No Reason: _____

Are you eligible to reapply for ATAP/TANF: Yes No Date able to reapply: ___/___/___

What TANF office did you receive assistance from: Please list: _____

EXPLAIN FULLY, how you have supported yourself during the past three (3) months *and* what has changed in your situation to cause you to apply for assistance. **Failure to complete this section will render this application incomplete & therefore will not be processed.**

Do you have an Individual Indian Money (IIM) account? Yes No

RECORD OF INCOME AND RESOURCES

Does anyone in your household have income from any source? Yes No
 If yes, list the name of household member(s), source of income and amounts below.

*****YOU ARE REQUIRED TO REPORT INCOME RECEIVED FROM THE FOLLOWING*****

SOURCE OF INCOME & RESOURCES	AMOUNT	NAME OF HOUSEHOLD MEMBER
Salary #1: Applicant's Income/Salary	\$	
Salary #2: Spouse's Income/Salary	\$	
Tips or Gratuities	\$	
ATAP –TANF-ASAP (State assistance)	\$	
Child Support and Alimony	\$	
Foster Care Payments	\$	
Adult Public Assistance (APA)	\$	
Social Security (SSA RETIREMENT)	\$	
Supplemental Security Income (SSI)	\$	
Disability Insurance (SSDI or private ins.)	\$	
Alaska State Permanent Fund (PFD)	\$	
Cashouts of Retirement or Pension Plans	\$	
State Longevity	\$	
Veteran's Benefit	\$	
Unemployment Insurance Benefits	\$	
Worker's Compensation	\$	
Food Stamps	\$	
Medicare/Medicaid	\$	
Native Corporation Dividends	\$	
Checking Account (provide statement showing balance)	\$	
Savings Account (provide statement showing balance)	\$	
Student Loans/Grants/Scholarships	\$	
Bingo or Pull Tab Winnings	\$	
Other Income	\$	
TOTAL MONTHLY INCOME	\$	



Native Village of Kotzebue
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PHONE: (907) 442-3467 FAX: (907) 442-2162
E-MAIL: john.stalker@gira.org

DATE: _____

I, _____, hereby authorize the release of information requested by the Native Village of Kotzebue, General Assistance Program. The requested information shall be used solely in the administration of General Assistance and will not be released to any other person or agency outside the General Assistance Program or its agents. I hereby authorize the Native Village of Kotzebue to obtain and exchange information related to my applications to participate in their programs. And, to arrange for such participations based on my employability assessment and plan to employment related activities. **This release of information shall be in effect while I am an applicant or recipient of General Assistance, and for any later inquiries pertaining to my eligibility and receipt of General Assistance benefits.**

Persons or organizations that may be contacted include, but are not limited to: the Department of Labor, the Department of Military Affairs, Alaska State Housing Authority, Regional Housing Authorities, Social Security Administration, local and tribal governments, State of Alaska ATAP, Tribal TANF or other public assistance program contractors and grantees, health care providers, tax assessors, banks and credit unions, Native corporations, landlords (including family/friends who are renting to applicant), employers, school authorities, and all departments and programs administered by the Native Village of Kotzebue.

FRAUD NOTICE: Under 18 U.S.C. §1001, the Federal Law concerning fraud states: “Whoever, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or devise a material fact, or makes or uses any false writing or documents, knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than five years or both.”

A REPRODUCTION OF THIS RELEASE IS AS VALID AS THE ORIGINAL

Applicant Signature

Signature of Witness if signed with an “X”

Printed Name of Applicant

Printed Name of Witness if signed with an “X”

Social Security Number

Date of Witness Signature

Date of Applicant Signature

**U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF INDIAN AFFAIRS**

OMB NO. 1076-0017
EXP: 03/31/2024
BIA 5-6602

Redetermination Date (3 months: ISP)/ (6 months: Case Plan) Date GA Recipient met ALL goals (mm/dd/yyyy)
(mm/dd/yyyy)/ Initials: ____/____/____ / _____ (mm/dd/yyyy)/ Initials: ____/____/____ / _____

INDIVIDUAL SELF-SUFFICIENCY (ISP)/ CASE PLAN (25 CFR Part 20)

ISP / Case Plan [Check all that Apply]

Name of Client: (Last, First, Middle): _____ **Date of Plan:** ____/____/____

What is/are your goals to achieve self-sufficiency?

Short-Term Goals:

Long-Term Goals:

BARRIERS TO CLIENT			STRENGTHS OF CLIENT
<input type="checkbox"/> Health	<input type="checkbox"/> Lack of/ Limited Transportation	<input type="checkbox"/> No Driver's License	<i>Identify strengths the client possesses:</i>
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lack of/ Limited Education	<input type="checkbox"/> Social Isolation	
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Criminal History	<input type="checkbox"/> Limited/No Jobs Available	
<input type="checkbox"/> Dependency	<input type="checkbox"/> Limited/ No Work History	<input type="checkbox"/> Homeless	
<input type="checkbox"/> Age Factors	<input type="checkbox"/> No Job Skills	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Disabilities			

STEPS NEEDED TO ACHIEVE SELF-SUFFICIENCY			
WORK ACTIVITIES	EDUCATION/ TRAINING	OTHER ACTIVITIES	CASE PLAN
<input type="checkbox"/> Job Search	<input type="checkbox"/> High School Diploma	<input type="checkbox"/> Life Skills Activities	<input type="checkbox"/> SSA Application
<input type="checkbox"/> Volunteer Work Experience	<input type="checkbox"/> GED	<input type="checkbox"/> Parenting Skills	<input type="checkbox"/> Medical Report
<input type="checkbox"/> Job Sampling or Job Shadow	<input type="checkbox"/> ESL (English as 2 nd Language)	<input type="checkbox"/> Childcare Assistance	<input type="checkbox"/> Decision Letters
<input type="checkbox"/> On-the-Job Training	<input type="checkbox"/> Adult Vocational Training	<input type="checkbox"/> Child Support	<input type="checkbox"/> Legal Assistance
<input type="checkbox"/> Employment Counseling	<input type="checkbox"/> Literacy Improvement	<input type="checkbox"/> Substance Abuse Treatment	<input type="checkbox"/> Care for Child Under Age 6
<input type="checkbox"/> Registration with Local Job Service	<input type="checkbox"/> Higher Education	<input type="checkbox"/> Counseling	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Job Readiness	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Driver's License Reinstatement	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Dental/Health Care	
		<input type="checkbox"/> Other: _____	

SELF SUFFICIENCY ACTION PLAN & GOALS

GOAL #1

Goal #1 Revised

ACTION STEPS FOR GOAL #1	DATE TO BE ACHIEVED	DATE COMPLETED
1.		
2.		

GOAL #2

Goal #2 Revised

ACTION STEPS FOR GOAL #2	DATE TO BE ACHIEVED	DATE COMPLETED
1.		
2.		

SOCIAL SERVICES WORKER'S ACTIVITY WITH TIMEFRAME (25 CFR 20.318)	DATE TO BE ACHIEVED	DATE COMPLETED
1.		
2.		

U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF INDIAN AFFAIRS

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____ By initialing you understand that the purpose of the Individual Self-Sufficiency Plan (ISP) is to meet the goal of employment through specific action steps and I am required to follow the steps developed in the ISP. I understand that I must participate in work activities and/or other activities and referrals developed in this plan that will promote my self-sufficiency. Failure to follow through with the ISP may constitute suspension from the General Assistance Program for a period of at least 60 days but not more than 90 days. I also understand that if there are any changes to be made that I will contact my Case Worker in a timely manner to ensure my success in the General Assistance Program.

____ By initialing you understand that the purpose of the Case Plan is to follow through with goals listed: (i.e.) Accessing other resource programs, keeping medical appt., etc. Failure to follow through with the steps identified in the Case Plan may constitute suspension from the General Assistance Program.

GA Recipient Signature

Date Signed

Social Services Worker Signature

Date Signed

Date Signature of Applicant

Date Signature of Social Service Worker

Date Signature of Bureau Line Office (if applicable)

Privacy Act Statement

25 CFR Part 20 and 25 U.S.C. 13 authorize the collection of this information. The information is confidential and is never disclosed without written clearance and consent of the applicant. The primary use of this information is to determine eligibility for financial assistance and services from the Bureau of Indian Affairs (BIA) Child Welfare, Burial, and Disaster programs. Additional disclosures of the information may be to other BIA or tribal officials in the conduct of their official duties pertaining to the application for financial assistance or services, or in the conduct of program review and to the Office of the Inspector General or the General Accounting Office when conducting an audit of BIA programs, or local law enforcement agency when the Agency becomes aware of violation or possible violation of civil or criminal law, and to the General Services Administration in connection with its responsibility for records management. This information will be entered into the BIA, Social Services system of records which can be obtained upon request from Chief, Division of Social Services, 1849 C Street, NW, MS-3647-MIB, Washington, DC 20240. No record contained therein may be disclosed by any means of communication to any person, or to another agency, except pursuant to a written request by, or with prior written consent of the individual to whom the record pertains. Executive Order 9397 authorizes the collection of your Social Security number. Furnishing the information is voluntary but failure to do so may result in disapproval of your application. If the BIA uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

Paperwork Reduction Act Statement

The information is being collected to determine applicant eligibility for financial assistance and services and to provide Bureau of Indian Affairs (BIA) managers with information for program planning, reporting and utilization. Response to this collection is required to obtain a benefit(s) required in 25 CFR 20. A Federal Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Public reporting for this form is estimated to average 1 hour per response, including the time for reviewing instructions, gathering and maintaining data, and completing the form. Direct comments regarding the burden estimate or any other aspect of this form to: Office of Regulatory Affairs & Collaborative Action - Indian Affairs, Information Collection Clearance Officer, 1849 C Street, NW, MS-3071, Washington, DC 20240.



Native Village of Kotzebue
P.O Box 296
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PHONE: (907) 442-3467 FAX: (907) 442-2162
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WORK SEARCH/WORK RELATED ACTIVITY SHEET

NAME OF APPLICANT: _____ **SSN:** ***/**/____ **DOB:** ____/____/____

Applicant:

Please read carefully. Ask your Welfare Assistance Case Worker to clarify if you do not understand these requirements.

1. All employable adults in your household are required to apply for a minimum of twelve (12) different jobs for the month that you have applied for Welfare Assistance.
2. You must complete six (6) work searches within two weeks from the date of your application.
3. The remaining six (6) work searches must be completed before the end of the month in which you applied.
4. Actively looking for work is one of the goals in your Individual Self-Sufficiency Plan (ISP).
5. Take the Work Search form to various businesses and submit an application for employment. The potential employer must sign and date the Work Search form which verifies that you have applied for work. Return the Work Search forms to the Welfare Assistance Worker.
6. You may also show proof that you are actively participating in work related activities such as obtaining a GED; doing consistent volunteer work; working with Job Service to develop your resume (work history). Provide proof to your Welfare Assistance Case Worker of these activities within two weeks of the date of your application. The proof is a document from the place where you are doing these work-related activities.

Date of your Application:

First 6 worksheets due:

Last 6 worksheets due:

If you do not complete the work searches, you will not receive GA.



Employer: Please complete the information below for the applicant who is pursuing employment with your organization or business.

NAME OF APPLICANT: _____

WORK SEARCH/WORK RELATED ACTIVITY # 1			
Date:		Job Title/Work Activity:	
Employer or Business Phone #:		Employer or Business Name:	
Employer or Business Address:			
Submitted a Complete Application	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was Applicant Offered Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Submitted a Resume	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Accept Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Applicant Interviewed for Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Refuse Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			

WORK SEARCH/WORK RELATED ACTIVITY # 2			
Date:		Job Title/Work Activity:	
Employer or Business Phone #:		Employer or Business Name:	
Employer or Business Address:			
Submitted a Complete Application	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was Applicant Offered Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Submitted a Resume	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Accept Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Applicant Interviewed for Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Refuse Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			

WORK SEARCH/WORK RELATED ACTIVITY # 3			
Date:		Job Title/Work Activity:	
Employer or Business Phone #:		Employer or Business Name:	
Employer or Business Address:			
Submitted a Complete Application	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was Applicant Offered Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Submitted a Resume	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Accept Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Applicant Interviewed for Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Refuse Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			



Employer: Please complete the information below for the applicant who is pursuing employment with your organization or business.

NAME OF APPLICANT: _____

WORK SEARCH/WORK RELATED ACTIVITY # 1			
Date:		Job Title/Work Activity:	
Employer or Business Phone #:		Employer or Business Name:	
Employer or Business Address:			
Submitted a Complete Application	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was Applicant Offered Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Submitted a Resume	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Accept Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Applicant Interviewed for Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Refuse Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			

WORK SEARCH/WORK RELATED ACTIVITY # 2			
Date:		Job Title/Work Activity:	
Employer or Business Phone #:		Employer or Business Name:	
Employer or Business Address:			
Submitted a Complete Application	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was Applicant Offered Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Submitted a Resume	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Accept Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Applicant Interviewed for Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Refuse Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			

WORK SEARCH/WORK RELATED ACTIVITY # 3			
Date:		Job Title/Work Activity:	
Employer or Business Phone #:		Employer or Business Name:	
Employer or Business Address:			
Submitted a Complete Application	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was Applicant Offered Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Submitted a Resume	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Accept Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Applicant Interviewed for Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did Applicant Refuse Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			



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NAME OF APPLICANT: _____

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Date:		Job Title/Work Activity:	
Employer or Business Phone #:		Employer or Business Name:	
Employer or Business Address:			
Submitted a Complete Application	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was Applicant Offered Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
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COMMENTS:			

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COMMENTS:			

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Date:		Job Title/Work Activity:	
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Employer or Business Phone #:		Employer or Business Name:	
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