Attachment II

OJT JOB PERFORMANCE REVIEW

Contract #	/ Business Services Representative / WDS	Month / Year

Participant Name	Last 4 digits of SSN

Employer	Supervisor	Phone #

	E	M	N	U
QUALITY OF WORK: Performs assigned duties. Output of product/services.	☐	☐	☐	☐
ABILITY TO WORK WITH OTHERS: Takes directions well. Responsible and courteous with associates and co-workers	☐	☐	☐	☐
WORK HABITS AND INITIATIVE: Prompt, active, keeps busy, uses time well, helps others	☐	☐	☐	☐
OVERALL EVALUATION: Include comments below if appropriate	☐	☐	☐	☐

E – Exceeds Job Standards M – Meets Job Standards N – Needs Improvement U – Unsatisfactory

Comments:

Participant Signature *Date*
(Optional, signature does not indicate concurrence)

Supervisor Signature *Date*

For County (WDD) Use Only:

OJT Completion Status (Check all that Apply):

☐ Completed Training / Retained

Hourly Wage : **$** _____ Hours per Week:_____

Green Job ☐ Yes ☐ No Fringe Benefits ☐ Yes ☐ No Health Benefits ☐ Yes ☐ No Eligible for UI ☐ Yes ☐ No

Job Title: _____

☐ Certification/s / Certificate/s Earned: _____

☐ Completed Training / Not Retained (provide explanation below or on additional sheet)

☐ Voluntarily Quit Date _____

☐ Terminated (provide explanation below or on additional sheet)

☐ Other: _____

Employer Name:	
Vendor Code:	
Street Address:	
City / State / Zip:	
Phone:	
Employer Contact Name:	

ON-THE-JOB TRAINING EMPLOYER INVOICE
San Bernardino County
WORKFORCE DEVELOPMENT DEPARTMENT
290 North D Street, Suite 600
San Bernardino, CA 92415-0046

Contract Number:	
Max Contract Amount: $	
Effective Contract Dates (from – to):	–
Training Reimbursement Rate: $	**hr**
Max Contract Training Hours:	
AJCC Location:	

_____ _____
Participant Name *Participant SSN (Last 4)*

Complete the section below for total hours worked during the OJT contract term. Each row represents months during the OJT contract term. Please total each month in "total" column.

MM/YY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total

Grand Total

County will round down reimbursement hours to a total of 8 hours per shift and/or down to the nearest .25 hour **Maximum** reimbursable hours **per day** = **8 hours** *(Excess time will not be reimbursed)* **Maximum** reimbursable hours **per month** = 160 **hours** *(Excess time will not be reimbursed)*

/ **/**

Participant Printed Name & Signature *Date* ***Supervisor Printed Name & Signature*** *Date*

Invoice will not be processed unless a Performance Evaluation is signed and included. Comments are required upon early termination.

County Use Only:

Total Reimbursable Training Hours: _____ **X** Reimbursement Hourly Rate **$** _____ **= Total Reimbursement Amount** **$** 0

Reviewed by Name: _____ Date: _____ BSR Supervisor Name/Signature: Keven Eldridge Date: _____

Funding Source ☐ Adult ☐ Dislocated Worker ☐ Other (specify):

Approved Amount to Reimburse **$** _____ Cumulative Reimbursement **$** _____ Remaining Balance **$** _____

Fiscal Office Use

Reviewed by Printed Name/Signature: _____ Date: _____ Comments: _____