**Agency Name/Program Name**

**Minnesota Family Investment Program (MFIP)**

**WORK EXPERIENCE ACTIVITY**

**VERIFICATION FORM**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **Work Experience Program Participant Name** |  | **Date** |

|  |
| --- |
| **AUTHORIZATION TO RELEASE INFORMATION**I hereby grant permission to release the information requested below as it relates to my participation in the MFIP Work Experience Program. This information may be shared among various departments within Hennepin County and with MFIP Employment Service Providers. This authorization expires one year from my signature date. |
| Work Experience Participant Signature | Date |

FOR COMPLETION BY WORKSITE EMPLOYER SUPERVISOR

The above person is participating in a work experience program designed to enhance their skills and provide career exploration prior to returning to the workforce. Participating in a work experience activity is an important part of our program. Commitment to maintaining the schedule below is important in their progress towards obtaining future employment. As part of this program we are required to obtain the following information and verify hours worked each month. Thank you for your cooperation in providing the information requested.

|  |  |  |  |
| --- | --- | --- | --- |
| (Business Name) |       | Supervisor’s Name |       |
| Street Address |       | Phone |       |
| City, State, Zip |       | Work Experience Start Date?  |       |

1. How long is the required/desired commitment for this work experience activity? .

2. Work experience job title?

3. Brief description of work experience duties:

5. What is the expected work experience schedule each week? **(Please complete the schedule below)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
| **Start****Time** |       |       |       |       |       |       |       |
| **End****Time** |       |       |       |       |       |       |       |

Please check all boxes that apply:

* I certify that this worksite is in compliance with OSHA and Minnesota Dept. of Labor and Industry Safety Standards.
* I certify that the Worksite Employer has provided the appropriate safety training applicable for this position and will maintain compliance with OSHA and Minnesota Dept. of Labor and Industry Safety Standards.
* Is this position part of a collective bargaining unit? Please check Yes or No: Yes \_\_\_\_ No \_\_\_ If yes, please have a union representative complete the box on page 2 under **Union Status**:
* This position is not the result of displacement, layoff or downsizing/termination or replacing a current employee for whom this position would be a promotion.

I certify that the above information is true to the best of my knowledge and that I have the authority to make such verifications on behalf of this employer/business.

Signature of Representative Printed Name Date

**PLEASE RETURN THIS FORM TO YOUR MFIP WORK EXPERIENCE REPRESENTATIVE:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|       |  |       |  |       |  |       |
| Staff Name |  | Phone |  | Fax |  | Email |

**Union Status:**

**If the host site is covered by a collective bargaining agreement complete the box below:**

|  |
| --- |
| **Position(s) requested through unpaid work experience covered under a union agreement? Yes \_\_\_ No \_\_** **I, the undersigned Union Local Representative, agree positions listed above may be filled using unpaid work experience participants. This position is not the result of displacement, layoff or downsizing/termination or replacing a current employee for whom this position would be a promotion****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Union Representative Title****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Union Local & Number Date**  |