

WIA Work Experience Trainee Evaluation

Trainee Information			
Trainee Name:		OSL Participant ID:	
Start Date:		End Date:	Job Title:
Worksite Information			
Worksite:			
Worksite Address:		Worksite Telephone:	
		Days/Hours of Operation:	
Supervisor:		Telephone:	
Alternate Supervisor:		Telephone:	

Please rate the Trainee for each characteristic utilizing the following scale:
 1 = Unsatisfactory 2 = Satisfactory 3 = Good 4 = Excellent

Item	Initial Rating	Mid-Term Rating	Final Rating
1. Cooperative	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
2. Follows Directions	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
3. Responsible	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
4. Takes Initiative	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
5. Skills Progress	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
6. Appearance	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
7. Attendance	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
8. Punctuality	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
9. Integrity	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
10. Productivity	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
11. Work Quality	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
12. Conduct/Attitude	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Average Rating: (Total Points ÷ 12)			
Comments:			
Date of Evaluation:			
Certification			
<i>I have discussed this performance evaluation with the Trainee, and certify that I have evaluated the skills objectively.</i>			
Supervisor Signature:			
<i>This performance evaluation has been discussed with me, and I certify that I have received training in the skills listed.</i>			
Trainee Signature:			

WORKFORCE INVESTMENT ACT

Work Experience Worksite Orientation

Worksite: _____ Telephone Number: _____

Worksite Address: _____

Worksite Supervisor: _____ Telephone Number: _____

Alternate Supervisor: _____ Telephone Number: _____

Acknowledgement of Receipt

This is to certify that I have received, read, and understand the rules, regulations, and instructions contained in this orientation manual. I have also received a copy of the job description(s) of the participant(s) whom I will be supervising.

Worksite Supervisor Signature

Date

Alternate Supervisor Signature (if applicable)

Date

WIA Representative Signature

Date

WIA Work Experience Incident Report

Worksite Supervisor: Please complete the following information and submit to: _____

WORKSITE INFORMATION							
Worksite:							
Worksite Address:				Worksite Telephone:			
				Days/Hours of Operation:			
Supervisor:					Telephone:		
Alternate Supervisor (if applicable):					Telephone:		
TRAINEE INFORMATION							
Trainee Name:					Telephone:		
Trainee Address:			City:			Zip:	
INCIDENT INFORMATION							
Location of Incident:			Date:			Time:	
Description of Incident:							
Injury Sustained:	<input type="checkbox"/> Yes <input type="checkbox"/> No		Type of Injury:				
Medical Treatment Received:	<input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Physician:				
Physician Address:			City:			Zip:	
COMPLETE THIS SECTION ONLY IF THE INCIDENT WAS REPORTED TO THE POLICE							
Police Station Name/Number:							
Police Station Address:			City:			Zip:	
Officer Name:					Telephone:		
CERTIFICATION							
Worksite Supervisor Signature:					Date:		
Trainee Signature:					Date:		