Public Education Entity Skills Training
Bi-Weekly Timesheet

Activity: ☐ ITA ☐ Supportive Services ☐ Other: ____________________

Participant Name	State ID #	Funding Source	WIOA Provider	WIOA Provider Contact

Training Provider	Contact Name	Contract #

Begin Date This Billing Period	End Date This Billing Period	Total Contract Period			Course Title (ITA only)
			to		

1. Has your monthly income changed within the last 30 days? (Exclude needs related payment.)

   Yes ☐ No ☐

Hours of attendance should be entered in each space. For absence enter "Ø"; for Holidays enter "HOL".

	Sat	Sun	Mon	Tue	Wed	Thu	Fri
Date							
Hours							
Date							
Hours							

PARTICIPANT CERTIFICATION: I certify that the above information accurately reflects the actual dates and times I attended class activities. I understand that federal and state laws for willful misrepresentation provide penalties.

Participant Signature: ____ Date: ____________________

FOR PROVIDER OF SERVICE USE ONLY				
Supportive Service Provided	**Rate of Pay**	**Total Units**		**Amount Due**
Childcare		Hrs.		
Mileage		Days		
Needs Related Payment		Hrs.		
			Total	

PROVIDER CERTIFICATION: I have reviewed the information contained in this request and certify that it is in accordance with my records.

Provider Authorized Representative Signature: __________________________________ Date: ____________________

This WIOA, Title I-financially assisted program/service is an equal opportunity employer/program. Auxiliary aids and services are available upon request to people with disabilities and/or limited English proficiency.