



APPLICATION & PREPARATION FOR HBI PLUMBING ADVANCED TRAINING PROGRAM

Center Name Little Rock Job Corps Center

Address 6900 Scott Hamilton Drive
 Little Rock, Arkansas 72209

Center Phone (501)618-2500 ext.

Point of Contact c/o Consuelo Whitney, ACT/WBL Coordinator
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Dear Center Staff / Advanced Training Coordinator / Student:

Thank you for your recent interest in the HBI Heating Ventilation and Air Conditioning Advanced Training Program! We are excited and look forward to helping students achieve their career development goals.

The program consists of 15 weeks of training equivalent to approximately 300 hours. There are three sessions a year. The first step is to complete the following application packet and submit it 30 days before the session begins. **The application and documentation will be reviewed to determine student eligibility.**

Session I

- Applications Due
- Student Arrival
- Classes Begin
- Classes End

Session II

- Applications Due
- Student Arrival
- Classes Begin
- Break
- Classes End

Session III

- Applications Due
- Student Arrival
- Classes Begin
- Classes End

STUDENT REQUIREMENTS

Prerequisites must be met for acceptance into the program. Required documentation is also noted below. Please ensure that all requested documents listed are submitted in order to expedite the application process. Any missing or incomplete documents will result in a delay in the transfer process.

- ✓ Completed application
- ✓ Social Security Card - **copy required**
- ✓ Must be 18 years or older
- ✓ High school diploma, GED or HSE - **copy required**
- ✓ Health clearance from receiving Center, including the Health Form provided in this packet (sealed in an envelope) - **copy required**
- ✓ Pathway Achievement Record (PAR) **copy required**
- ✓ Valid driver's license - **copy required**
- ✓ Current Student Profile 640 (CIS) - **copy required**
- ✓ All Case Notes (CIS) - **copy required**
- ✓ Updated resume - **copy required**
- ✓ Center Safety Officer (CSO) report and/or Student Conduct Profile Report (CIS) from sending Center; must reflect positive discipline - **copy required**
- ✓ TABE scores of 580 (reading) and 580 (math) or higher
- ✓ Completion of a Job Corps Pre-Apprentice Electrical, Building Construction Technology (BCT), Facilities Maintenance (FM), Solar Photovoltaic Tech or HVAC program (HBI preferred) - **copy of TAR and all applicable certificates required**
- ✓ Completion of OSHA 10 Safety Training - **copy of certificate required**
- ✓ Written letter of recommendation from sending Career Technical Skills Training program instructor

HBI ADVANCED PROGRAM APPLICATION FORM

Complete the following information electronically using Acrobat or Adobe Reader 9.0 or later. If you do not have the proper software to complete the form(s) electronically, please print the form and complete a hardcopy with blue or black ink.

SENDING CENTER CONTACT INFORMATION

Center Name:

Staff Name: Staff Title:

Office Phone: Cell:

Fax: Email:

STUDENT INFORMATION

Last Name: First Name:

Home Address:

Home Phone: Cell:

Select one: Male Female

Select one: HSD GED HSE

Date Achieved: Click in the field to display a drop-down date selection option.

Career Technical Trade Completed:

If not yet completed, estimated completion date:

TABE Reading Level: TABE Reading Score:

TABE Math Level: TABE Math Score:

Total # of AWOL days:

Total # of unexcused absences: Total # of unexcused tardies:

Upon trade completion, is student willing to move to another city and/or state if necessary? Select one: Yes No

HBI ADVANCED PROGRAM APPLICATION FORM

I certify that meets the eligibility criteria and has enclosed a written letter of recommendation from the Career Technical Training Instructor noted below.

Center Director Signature:

Date:

CTT Manager Signature:

Date:

CTT Instructor Signature:

Date:

The final step for the applicant will be the opportunity to have an interview with center staff and/or trade instructor. This process will help the student, and the staff, determine suitability for the advanced training program. We will make arrangements via email if we wish to schedule a virtual meeting or phone interview with the applicant.

STUDENT TRANSFER HEALTH FORM

Complete the following medical information and forward to the receiving center in a sealed envelope marked "confidential" along with this application packet. To complete the form electronically, Acrobat or Adobe Reader 9.0 or later must be used. If you do not have the proper software to complete the form(s) electronically, please print the form and complete a hardcopy with blue or black ink.

Trainee Name: Date of Birth: Click in the field to display a drop-down date selection option.

Age: CIS ID#:

Date of Entry: Transferring Center:

Date of Transfer: Receiving Center:

Insurance:

Allergies:

Medication/Dosage:

Medical Conditions:

Upcoming Appointments:
(if applicable)

MEDICAL HEALTH

Date of Last Physical Exam:

Height: Weight: BMI:

Vision Exam: Contacts Glasses Color Deficit: Yes No

Hearing Exam:

Cleared for Full Program/Sports: Yes No Date Cleared:

MEDICAL HEALTH CONTINUED

Activity Restrictions:

Date of Last Td or Tdap: Date of Last CXR:

Date of Last PPD: Date Cleared: Yes No

Date TB Treatment Received: Date Treatment Completed:
(if applicable) (if applicable)

Medical Summary:

Center Physician Signature: Date:

Update Immunizations: Complete

Immunization records enclosed or faxed. Complete

ORAL HEALTH

Dental Priority Classification: Priority 3 Priority 4

Last dental appointment within 1 month before transfer date:

Orthodontics: Yes No If yes, date of last orthodontic visit:

Address and telephone number of orthodontic office after student transfers:

Dental Summary, including treatment needs:

Center Dentist Signature: Date:

TEAP

Entry Toxicology: Negative Positive

If positive, list drugs:

Suspicion Testing Date:

Results:

If additional Suspicion Testing,
list dates & results here:

Alcohol Incident Date:

If additional alcohol incidents, list dates here:

Attended TEAP Intervention Services: Yes No List dates here:

TEAP Summary:

TEAP Specialist Signature:

Date:

MENTAL HEALTH

Mental health diagnoses:

Last CMHC Appointment (*if applicable*):

List dates of leave/MSWR(s) for
mental health related reasons:

Mental Health
Summary:

CMHC Signature:

Date: