



**Building Careers.
Changing Lives.**

**APPLICATION & PREPARATION FOR
Home Builders Institute (HBI)
ELECTRICAL
ADVANCED TRAINING PROGRAM**

Center Name: Delaware Valley Job Corps

Address: 9368 State Route 97
Callicoon, New York 12723-0846

Send Applications To: Eric Possemato, AT Electrical Instructor
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Nathan "Kyle" Stevens, Regional Program Manager
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(918) 869-9660

Mary Hammons, Advanced Training Coordinator
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(904) 891-2615



Dear Center Staff / Advanced Training Coordinator / Student:

Thank you for your recent interest in the HBI Advanced Training Program! We are excited and looking 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 prior to the start of the session. ***The application and documentation will be reviewed to determine student eligibility.***

SESSION I

Application Due Date:

Student Arrival Date:

Classes Begin Date:

Break (if applicable):

Classes End Date:

SESSION II

Application Due Date:

Student Arrival Date:

Classes Begin Date:

Break (if applicable):

Classes End Date:

SESSION III

Application Due Date:

Student Arrival Date:

Classes Begin Date:

Break (if applicable):

Classes End Date:



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STUDENT REQUIREMENTS



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

- ☐ Must Be 18 Years or Older
- ☐ Completed Application
- ☐ Social Security Card – ***COPY REQUIRED***
- ☐ Must Have a 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 (not a Learner's Permit) – ***COPY REQUIRED***
- ☐ Current Student Profile 640 (CIS) – ***COPY REQUIRED***
- ☐ All Case Notes (CIS) – ***COPY REQUIRED***
- ☐ Updated Résumé – ***COPY REQUIRED***
- ☐ Center Safety Officer (CSO) report and/or Student Conduct Profile Report (CIS) from sending center. It 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 TAB AND ALL APPLICABLE CERTIFICATES REQUIRED***
- ☐ Completion of OSHA 10 Safety Training – ***COPY OF CERTIFICATE REQUIRED***
- ☐ Written Letter of Recommendation from Sending Center Technical Skills Training Program Instructor

HBI ADVANCED PROGRAM APPLICATION FORM

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

SENDING CENTER CONTACT INFORMATION

Center Name:

Staff Name:

Staff Title:

Office Phone:

Cell:

Email:

Fax:

STUDENT INFORMATION

Last Name:

First Name:

Home Address:

Personal Email:

Cell:

Select One: Male

Female

Select One: HSD

GED

HSE

*Click in the field to display a
drop-down date selection option.*

Date Achieved:

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 the center staff and/or the trade instructor. This process will help the student, and the staff, determine suitability for the Advanced Training Program. We will make arrangements through 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 it 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 higher must be used. If you do not have the proper software to complete the form(s) electronically, please print the form and complete a hard copy with blue or black ink.

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

Trainee Name:

Date of Birth:

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:

Cleared: ☐ Yes ☐ No Date Cleared:

Date TB Treatment Received:
(if applicable)

Date Treatment Completed:
(if applicable)

Medical Summary:

Center Physician Signature:

Date:

Updated Immunizations: ☐ Complete

Immunization Records Enclosed or Faxed: ☐ Complete

ORAL HEALTH

Dental Priority Classification:

☐

Priority 3

☐

Priority 4

Last Dental Appointment within one (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,
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 Diagnosis:

Last CMHC Appointment (*if applicable*):

List Dates of Leave / MSWR(s) for
Mental Health Related Reasons:

Mental Health
Summary:

CMHC Signature:

Date: