Allied Health West Supplemental Form

PO Box 415, Coos Bay OR 97420

Please complete this supplemental form and return it directly to Alane Jennings, Apprenticeship Coordinator. **Please do not ask your employer to forward it, as this information is private.**
For questions, contact Laura Pumphrey at lpumphrey@sowib.org

Allied Health West (AHW) will not discriminate against apprenticeship applicants or apprentices based on race, color, religion, national origin, sex (including pregnancy and gender identity), sexual orientation, genetic information, or because they are an individual with a disability or a person 18 years old or older. AHW shall take affirmative action to provide equal opportunity in apprenticeship and shall operate the apprenticeship program as required under the Oregon Plan for Equal Employment Opportunity in Apprenticeship and Title 29 of the Code of Federal Regulations, part 30. This is an equal opportunity program, and auxiliary aids and services are available upon request to individuals with disabilities.

The Division hopes, through collection of this data, to improve the apprenticeship program both for those presently enrolled and for future apprentices. Thank you.

Candidate Information

Full Name: _____ Date: _____
First *Last* *M.I.*

Gender:

☐ Male ☐ Female ☐ Non-Binary/Other

Date of Birth: *(mm/dd/yyyy) Must be 18 or over* Age:

Ethnicity:

☐ Hispanic or Latinx ☐ Not Hispanic or Latinx

Race:

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The following describes me currently:

☐ Underemployed - (your job does not provide the income necessary to support your household)
☐ Receiving Food Stamps/SNAP Benefits (within last 6 months)
☐ NONE APPLY

Veteran Status:

☐ No, I am not a veteran or spouse of a veteran ☐ Yes, I am a veteran/spouse of a veteran (Honorable Discharge, DD214)

Disability: *(providing information about disability status is voluntary)*

☐ Yes ☐ No ☐ Decline to disclose

My signature below indicates that I certify the information on this application is true to the best of my knowledge.

Participant Name *(please print)* Participant Signature Date

The Allied Health West Apprenticeship program is an equal opportunity employer/program, and auxiliary aids and services are available upon request to individuals with disabilities. This workforce product was 100% funded by grants awarded by the U.S. Department of Labor's Employment and Training Administration ($353,000 & $692,000). The product was created by the grantee and does not necessarily reflect the official position of the U.S. Department of Labor. The U.S. Department of Labor makes no guarantees, warranties, or assurances of any kind, express or implied, with respect to such information, including any information on linked sites and including but not limited to, accuracy of the information or its completeness, timeliness, usefulness, adequacy, continued availability, or ownership.

(1) Your Right to Equal Opportunity

(2) It is against the law for a Sponsor of an apprenticeship program registered for Federal purposes to discriminate against an apprenticeship applicant or apprentice based on race, color, religion, national origin, sex, sexual orientation, age (18 years or older), genetic information, or disability. The Sponsor must ensure equal opportunity with regard to all terms, conditions, and privileges associated with apprenticeship. If you think that you have been subjected to discrimination, you may file a complaint within 300 days from the date of the alleged discrimination or failure to follow the equal opportunity standards with Oregon Bureau of Labor and Industries, 800 NE Oregon Street, Suite 1045, Portland, OR 97232. You may also be able to file complaints directly with the EEOC, or State fair employment practices agency at the above location.

(3) Each complaint filed must be made in writing and include the following information:

(a) Complainant's name, address and telephone number, or other means for contacting the complainant;

(b) The identity of the respondent (i.e. the name, address, and telephone number of the individual or entity that the complainant alleges is responsible for the discrimination);

(c) A short description of the events that the complainant believes were discriminatory, including but not limited to when the events took place, what occurred, and why the complainant believes the actions were discriminatory (for example, because of his/her race, color, religion, sex, sexual orientation, national origin, age (18 or older), genetic information, or disability);

(4) The complainant's signature or the signature of the complainant's authorized representative.