REGION VI WIOA/ITA INVOICE –*Revised 1/8/2024*

Training Provider Name and Address

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Phone No.: __________________________

Mail to: Region VI WDB Office
17 Middletown Road
White Hall, WV 26554

FEIN #: ___________________________

Training Provider Invoice #:_________________
Funding Source: ____________________________
(Adult OR Dislocated Worker)

1st Year Midpoint

PARTICIPANT	MACC ID#	SIGNATURE OF PARTICIPANT	AMOUNT *

*remainder of 1st year awarded amount

Total # of program hours/months required	**Total # of program hours/months completed**

I hereby attest that the above WIOA Participant has completed at least 50% of their 1st Year program hours/months as per the Region VI ITA Invoicing Policy and Procedure.

____ ________________________________
Training Provider **Date**