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

Training Provider Name and Address

_____

_____

_____

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)

2nd Year Midpoint

PARTICIPANT	MACC ID#	SIGNATURE OF PARTICIPANT	AMOUNT *

*remainder of 2nd 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 2nd Year program hours/months as per the Region VI ITA Invoicing Policy and Procedure.

_____ _____

Training Provider **Date**