THE HOPI TRIBE

ADULT VOCATIONAL TRAINING PROGRAM
REQUIRED DOCUMENTS

The following documents must be submitted to determine eligibility of services.

1. Birth Certificate(s) *(applicant and dependents)*
2. Social Security Card *(applicant)*
3. Tribal Enrollment Card *(applicant)*
4. Selective Service Registrant/Acknowledgement Letter *(males 18 to 26 years of age)* or Military DD214.
5. Official High School transcripts or GED tests scores.
6. Official transcripts from Post-Secondary and/or Vocational Schools
7. Marriage License or Divorce Decree
8. Statement of Medical Exam (Physical Exam form)

For more information call: (928) 734-3542
Adult Vocational Training Program
P.O. Box 123 Kykotsmovi, Arizona 86039

THE HOPI TRIBE

Adult Vocational Training Program
Application

Last Name: _____ First Name: _____ MI:_____

Address: _____ _____ _____ _____
P.O. Box/Street Address *City* *State* *Zip Code*

Social Security #:_____ Age: _____ Birthdate: _____

Phone #:_____ Message #:_____ Email: _____

Hopi Tribal Enrollment #: _____ Gender: Male ☐ Female ☐

Marital Status: Single: ☐ Married: ☐ Divorced/Separated: ☐ Widowed: ☐

Selective Service Registration #: *(For males 18-26 years of age.)* _____

Veteran Status: ☐ More than 180 days ☐ Less than 180 days ☐ No

Do you acknowledge Disability? Yes ☐ No ☐

EDUCATIONAL DATA

High School Attended: _____

Month/Year Graduated: _____ If not a graduate, highest grade completed: _____

GED Month/Year Obtained: _____ Testing Site: _____

Name of College/University attended *(Most Recent)*: _____

Year Graduated: _____ Type of Degree earned: _____ Major: _____

Name of Vocational Training attended *(most recent*): _____

Date Completed: _____ Certificate: ☐ Diploma: ☐

Are you currently enrolled in any school/training institution? Yes ☐ No ☐

If yes, Name and address of school attending: _____
_____
_____

Have you previously applied to any of our programs? *(If yes, which programs and year?)* Yes ☐ No ☐

Adult Vocational training Program (AVTP) ☐_____ Grants & Scholarship Program (HTGSP) ☐ _____

Workforce Innovation Opportunity Act Program (WIOA) ☐ _____

Hopi Vocational Rehabilitation Program ☐ _____

Employment Data

Employment Status: Employed ☐ Unemployed ☐ Underemployed ☐ Self-Employed ☐

Unemployment Status: Claimant ☐ Exhausted ☐ Neither ☐

Seeking Employment: Yes ☐ No ☐

Work History: List most recent employment *(Attach additional work history)*

Employer: _____ Job Title: _____

Address: _____ Employed From: _____ To: _____

Job Duties: _____

_____

Hourly Wage: _____ Reason for leaving: _____

INCOME DATA

Does your family receive any of the following? *(If yes, please check what type)*

TANF (Cash Assistance) ☐ Social Security ☐

SNAP (Supplemental Nutrition Assistant Program) ☐ Child Support ☐

General Assistance (GA) ☐ Alimony ☐ Jobs Program Participant (JOBS) ☐

INCASE OF AN EMERGENCY, PLEASE CONTACT

Name: _____ Relationship to you:_____

Address: _____ Phone #: _____

By my signature, I certify the information provided is true and best of my knowledge and that all programs under The Hopi Tribe Higher Education & Workforce Developmental Programs shall have access to this information for program related purposes.

Signature of Applicant: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(If Applicant is under the age of 18)

THE HOPI TRIBE

Adult Vocational Training Program
Statement of Medical Examination
(To be completed by Physician)

Name: _____ Date of Birth: _____

Address: _____

Medical History

Disease	When Diagnosed	Treatment	Resolved Chronic or Frequent Occurrence(s)
Hypertension			
Diabetes			
Heart Disease			
Kidney Disease			
Tuberculosis			
Seizures			
Anxiety/Nervous Reactions			
Ulcers/Gastritis			
Respiratory Infections			
Gastroenteritis			
Ear Infections			
Alcoholism			
Musculoskeletal			
Sexually Transmitted Disease			
AIDS			
Other			

Comments:

_____

_____

Immunizations:

DPT: _____OPV: _____

DT:_____ MMTR: _____ PPD: _____

Current Medications:

_____

_____

Will This Person Need: *(Please Circle Yes or No)*

1. **Follow-up for med./Surg. Problems? Yes No**
2. **Glasses? Yes No**
3. **Dental Work? Yes No**
4. **Immunizations? Yes No**
5. **Hearing Problems? Yes No**

Physical Exam:

WT: _____ HT:_____ B/P:_____ Vision:_____

Hearing: Normal: _____ Abnormal: _____

	Normal	Abnormal
HEENT		
Neck		
Thorax		
Breast Axiillae		
Lungs		
Heart		
Abd.		

	Normal	Abnormal
Extremities		
Musculoskeletal		
Spine		
Skin		
Genitalia		
Neurological		
Medical Status		

If abnormal, please explain:

_____

_____

_____

LAB: **HCT:** **UA:**

OB/GYN hx: P. _____ G._____ Pap _____

Comments:

_____

_____

_____

Allergies, Food Sensitivity:

_____

_____

Service Unit: _____ MD Signature: _____ Date: _____