SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

WORKFORCE SERVICES

sdjobs.org

TRADE ADJUSTMENT ASSISTANCE

REQUEST FOR WAIVER- REVERSION ONLY

Petition Number:	
Certified Employer:	
Within 8 weeks of certification?	☐ Yes ☐ No
Within 16 weeks of separation?	☐ Yes ☐ No

Certification Date:	
Separation Date:	
Date of Request:	

Full Name:_____ Last for Digits of SSN: _____

Address: _____ City:_____ State:_____ Zip: _____

REQUEST FOR WAIVER

Under qualifying requirements for TRA benefits, waivers may be issued if it is determined that it is not feasible or appropriate for workers to be enrolled in training.

☐ Health	The worker is unable to participate in training due to health.
☐ Enrollment Unavailable	The first available enrollment date for the approved training for the worker is within 60 days after the date of this waiver. Or for extenuating circumstances: ___ a. training program abruptly cancelled; or ___ b. First training enrollment date is past the end of the 60 day period; or ___ c. Injury or illness adversely affecting ability to enroll in training; or ___ d. Other-_____
☐ Training not Available	Training is not reasonably available from government or private sources. Or, suitable training for the worker is not available at a reasonable cost or no training funds are available.

WORKER CERTIFICATION

I understand that I may be required to provide documentation supporting the reasons for requesting a waiver. I understand issued waivers will be reviewed every 30 days and I may be required to provide information or documentation supporting continuation. The information provided in this request is correct to the best of my knowledge. I understand penalties are provided for willful misrepresentation.

Worker Signature: _____ Date: _____/_____/_____

Determination by State Agency

☐ This request for a waiver to the enrolled in training requirement is approved.

a. Effective dates are From: _____ To: _____
(Date signed) *(26 weeks from the date signed)*

b. This waiver will be reviewed every 30 days. Documentation may be required for a determination of continuation

c. This waiver may be revoked at any time if it is determined to no longer apply to the workers situation.

☐ This request for issuance of a waiver is denied for the following reason:

State Agency Representative: _____ Office:_____

Signature:_____ Determination Date:_____

APPEAL RIGHTS: This is the final determination. If you wish to appeal, you must follow the procedure set out under Other Grievances in our Equal Opportunity is the Law Form 2 found at https://dlr.sd.gov/workforce_services/wioa/manual.aspx