



# VIRGINIA EMPLOYMENT COMMISSION

REQUEST FOR DETERMINATION OF ENTITLEMENT TO TAA/TRA  
TRADE ACT OF 1974, AS AMENDED

### FOR OFFICE USE

LOCAL OFFICE NO.

PETITION NO.

SEX

MALE

FEMALE

FILED DATE

WORKER NAME (First, Middle Initial, Last)

SOCIAL SECURITY NO.

CERTIFICATION DATE

ADDRESS (No., Street)

DATE OF BIRTH (Mo., Day, Yr.)

IMPACT DATE

CITY

STATE

ZIP CODE

LAST OCCUPATION

EXPIRATION DATE

QUALIFYING PERIOD: Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_

(Dates to be entered by State Agency for 52 calendar week period ending with the week of separation.)

### A. SEPARATION AND WAGE INFORMATION FOR ADVERSELY AFFECTED EMPLOYMENT (To be completed by worker only for the qualifying period shown above.)

1. NAME OF FIRM

2. ADDRESS OF FIRM (No., Street)

2a. City

State

Zip Code

SUBDIVISION:

3. DATES OF EMPLOYMENT

4. NO. WEEKS EARNED \$30 OR MORE

5. DATE OF SEPARATION

FROM \_\_\_\_\_ TO \_\_\_\_\_

6. STATE OF SEPARATION

**Virginia**

7. TRA QUALIFYING BENEFIT YEAR BEGINNING DATE

8. TYPE OF SEPARATION

CHECK ONE:  TOTAL  
 PARTIAL

9. REASON FOR SEPARATION

CHECK ONE:  LACK OF WORK  
 OTHER

10. IF REASON FOR SEPARATION WAS FOR OTHER THAN LACK OF WORK, EXPLAIN

### B. OTHER QUALIFYING INFORMATION

(To be completed by worker by checking appropriate boxes. All "Yes" answers must be explained.)

1. DID YOU WORK FOR ANY OTHER EMPLOYER AFTER THE EMPLOYER SHOWN IN SECTION A?

YES

NO

EMPLOYER NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE OF SEPARATION \_\_\_\_\_

REASON FOR SEPARATION \_\_\_\_\_

2. HAVE YOU FILED A REQUEST FOR A DETERMINATION OF ENTITLEMENT TO TRADE READJUSTMENT ALLOWANCE PRIOR TO THIS APPLICATION?

STATE IN WHICH FILED \_\_\_\_\_

DATE FILED \_\_\_\_\_

3. DO YOU HAVE ENTITLEMENTS TO UNEMPLOYMENT INSURANCE BENEFITS?

PAYING STATE Virginia

4. HAVE YOU RECEIVED UNEMPLOYMENT INSURANCE BENEFITS OR TRAINING ALLOWANCES SINCE THE EMPLOYMENT SHOWN IN SECTION A?

PAYING STATE \_\_\_\_\_

NAME OF PROGRAM \_\_\_\_\_

5. SINCE THE EMPLOYMENT SHOWN IN SECTION A, HAVE YOU REFUSED TO ACCEPT REFERRAL TO, OR HAVE YOU FAILED TO REPORT TO A REFERRAL TRAINING PROGRAM?

STATE IN WHICH OCCURRED \_\_\_\_\_

NAME OF PROGRAM \_\_\_\_\_

CONTINUED ON REVERSE

OTHER QUALIFYING INFORMATION (CONTINUED)

(To be completed by worker by checking appropriate boxes. All "Yes" answers must be explained.)

6. ARE YOU NOW RECEIVING ANY TRAINING? <div style="float: right; margin-left: 100px;">                     YES <input type="checkbox"/>      NO <input type="checkbox"/> </div>	STATE IN WHICH TRAINING IS BEING CONDUCTED _____ NAME OF PROGRAM _____ DATE ENTERED _____
7. ARE YOU ENROLLED IN, OR HAVE YOU COMPLETED AN APPROPRIATE TRAINING PROGRAM SINCE YOUR EMPLOYMENT IN SECTION A? <div style="float: right; margin-left: 100px;"> <input type="checkbox"/>      <input type="checkbox"/> </div>	AGENCY PROVIDING TRAINING PROGRAM _____ DATE ENROLLED/COMPLETED TRAINING PROGRAM _____

NOTICE TO CLAIMANTS

The Privacy Act of 1974 requires that you be furnished with this statement because you are being asked to furnish your Social Security Account Number on the claim forms given to you. Your Social Security Number is solicited under the authority of the Internal Revenue Code of 1954. Disclosure of your Social Security Number for this purpose is MANDATORY, and must be entered on the forms you submit to claim unemployment compensation.

Your Social Security Number will be used to report your unemployment compensation to the Internal Revenue Service as income that is potentially taxable, to determine your eligibility benefits, compute the amount of benefits to which you may be entitled, and for statistical purposes. This information will be disseminated to other governmental agencies subject to the restrictions of the Virginia Privacy Protection Act for their use in the proper administration of law. Failure to provide the requested information will make you ineligible to receive benefits.

C. WORKER CERTIFICATION

I give this information to support my request for a determination of entitlement to Trade Readjustment Allowances. The information contained in this request is correct and complete to the best of my knowledge. I understand that penalties are provided for willful misrepresentation made to obtain allowances to which I am not entitled.

SIGNATURE OF WORKER	DATE OF THIS REQUEST
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D. STATE AGENCY CERTIFICATION

I have witnessed the worker's signature shown and have discussed with the worker the statements made. Based upon my knowledge of the facts, the statements appear to be correct.

SIGNATURE OF STATE AGENCY REPRESENTATIVE	DATE
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FOR OFFICE USE:  
 PAYING STATE IS \_\_\_\_\_ BASED ON:

- STATE OF SEPARATION
- STATE OF UI ENTITLEMENT

REMARKS

  
  
  
  
  
  
  
  
  
  

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INTRASTATE ORIGINAL: TRA MONETARY DETERMINATIONS UNIT ROOM 214 COPY: Local Office File	INTERSTATE ORIGINAL: With IB-1 or IB-2 to Liable State COPY: Local Office File
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