



On-the-Job Training Grant Reimbursement Request Form

Program Start: **September 1, 2025**

Program End Date: **August 31, 2026**

Population Served: **Adult, Business**

Agency: **Dept. of Labor**

Source Of Funding: **State**

Reimbursement Request Form

Contract #: _____

Business: _____

Tax ID#: _____

Contact Name: _____

Phone #: _____

Address: _____

City: _____

NY

Zip: _____

Date(s)	Trainee Name	Training Total Cost	Req. Reimbursement	Proof Attached
_____	_____	_____	_____	<input type="radio"/> Yes
_____	_____	_____	_____	<input type="radio"/> Yes
_____	_____	_____	_____	<input type="radio"/> Yes
_____	_____	_____	_____	<input type="radio"/> Yes
_____	_____	_____	_____	<input type="radio"/> Yes
_____	_____	_____	_____	<input type="radio"/> Yes
_____	_____	_____	_____	<input type="radio"/> Yes
_____	_____	_____	_____	<input type="radio"/> Yes
_____	_____	_____	_____	<input type="radio"/> Yes
_____	_____	_____	_____	<input type="radio"/> Yes

We agree to supply 6-month follow-up retention report:

☐ Yes

We agree to keep all records pertaining to the grant for 7 years:

☐ Yes

I certify under penalties of perjury that all laws, regulations, policies and procedures governing the expenditures of these public funds have been complied with, that expenses are true and correct, and that expenditures included in this reimbursement request were used solely for the purpose specified in the award for this contract. I certify that the following statements are true.

- All the employees listed above participated in training as specified.
- All the employees listed above are on the payroll of my company and are working in New York.
- I understand that the Amherst Chamber of Commerce or NYS may request to see additional documentation to determine proof of payment or participation in training.
- I am authorized to provide this information for my organization.

Signed: _____

Date: _____

Amherst Chamber of Commerce
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