



EMPLOYER COMMITMENT FORM 2008/2009

FAX TO: 0114 281 5785

Name of Business:	
Business Address:	
Town:	
Postcode:	

Telephone No:	
Fax Number:	
E-mail address:	@
Managers Name:	
Job Title:	
Secondary Contact:	
Job Title:	

Number of Employees:	
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It is expected that the learners will be allowed time off to study. How many hours will you allow per month? Less than 4 () Less than 8 () More than 8 ()
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What is the best day for the training provider to contact you?						
Mon	Tues	Wed	Thurs	Fri	Sat	Sun

May the funding body contact you?	Yes / No
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What date would you like to commence training?		
Day	Date	Month

Name	Role	Course	Age	EU Resident for 3 Years or more?	Any Current Qualifications?
				Yes / No	
				Yes / No	
				Yes / No	
				Yes / No	
				Yes / No	
				Yes / No	
				Yes / No	
				Yes / No	
				Yes / No	
				Yes / No	

I agree to my employees named above participating in the training courses stated. I understand that once the employee has enrolled they will be expected to complete the course.

Employers Signature	
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Print Name	
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PLEASE POST TO: CQM LEARNING LIMITED, 3 WESTBROOK COURT, SHARROW VALE ROAD, SHEFFIELD, S11 8YZ