



**TRAINING NOMINATION AND EMPLOYEE ASSESSMENT**

**Delegated Examining Training**

Training Location and Dates: \_\_\_\_\_

Training Dates Requested: \_\_\_\_\_

Agency Contact Person and  
Phone *(if different from nominee)*: \_\_\_\_\_

Indicate the type of training: Initial \_\_\_\_\_ or Re-Certification \_\_\_\_\_

Name of Nominee: \_\_\_\_\_

Title, Series, and Grade: \_\_\_\_\_

Length of Federal Staffing  
Experience: \_\_\_\_\_

Agency Name and Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nominee Telephone #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Delegation Agreement no.: \_\_\_\_\_

Employee Signature and Date: \_\_\_\_\_

Supervisor Signature and Date: \_\_\_\_\_