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: ______________________________

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Nominee Telephone #: ______________________________

E-mail Address: ______________________________

Delegation Agreement no.: ______________________________

Employee Signature and Date: ______________________________

Supervisor Signature and Date: ______________________________

OPM 1674
July 2004