



The information on this form is confidential and will be used only to report to the funding organizations, provide client services, inform you about and improve the SBDC services. The estimated time to fill out the form is three minutes.

DATE 11/17/2020		NAME OF TRAINING Generating Predictable Referrals for Your Business			
COMPANY NAME (leave blank if not in business)			ARE YOU THE BUSINESS OWNER? <input type="checkbox"/> Yes <input type="checkbox"/> No		
FIRST NAME		M.I.	LAST NAME		
EMAIL					
PHONE COMPANY OR HOME			CELL		
ADDRESS (if in business, provide company address) STREET					
CITY		ST	ZIP	COUNTY	
GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Choose not to respond		RACE <input type="checkbox"/> Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American		<input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Choose not to respond	
HISPANIC ORIGIN <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Choose not to respond					
VETERAN STATUS <input type="checkbox"/> Non-Veteran <input type="checkbox"/> Service-Disabled Veteran <input type="checkbox"/> Veteran <input type="checkbox"/> Choose not to respond		MILITARY STATUS <input type="checkbox"/> Active Duty <input type="checkbox"/> Military Spouse <input type="checkbox"/> National Guard <input type="checkbox"/> National Guard – Active Duty			<input type="checkbox"/> None <input type="checkbox"/> Reservist <input type="checkbox"/> Reservist – Active Duty <input type="checkbox"/> Choose not to respond
DISABLED <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Choose not to respond					

If in business, turn over and complete Company Information.

Company Information

(if currently in business)

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BUSINESS TYPE (Manufacturing, Construction, Technology, Retail, etc.)

DATE COMPANY ESTABLISHED

/ /

OWNERSHIP GENDER

% Male

% Female

NUMBER OF FULL-TIME EMPLOYEES

NUMBER OF PART-TIME EMPLOYEES

GROSS REVENUE/SALES FOR MOST RECENT BUSINESS YEAR

\$

COMPANY LEGAL STATUS

(LLC, Sole Proprietor, S-Corp, etc.)

PRODUCTS OR SERVICES

I request training and/or business counseling service from the Ohio Small Business Development Centers (SBDC), funded in part through a Cooperative Agreement with the U.S. Small Business Administration (SBA). I agree to cooperate should I be selected to participate in surveys designed to evaluate these services, impact, and/or make improvements on services. I permit SBA or its agent the use of my name and address for SBA surveys and information mailings regarding SBA products and services (Yes 0 No 0). I understand that any information disclosed will be held in strict confidence. SBA will not provide your personal information to commercial entities.

I authorize SBA to furnish relevant information to the assigned management counselor(s). I further understand that the counselor(s) agrees not to: 1) recommend goods or services from sources in which he/she has an interest, and 2) accept fees or commissions developing from this counseling relationship. In consideration of the counselor(s) furnishing management or technical assistance, I waive all claims against SBA personnel, and that of its Resource Partners and host organizations, arising from this assistance. Please note: The estimated burden for completing this form is 3 minutes. Comments on the burden should be sent to: U.S. Small Business Administration, 409 3rd Street, SW, Washington, DC 20416, and to: Desk Officer SBA, Office of Management and Budget, New Executive Office Building, Room 10202, Washington, D.C., 20503. OMB Approval (3245-0324). PLEASE DO NOT SEND FORMS TO OMB.

SIGNATURE

Not Required

DATE

Not Required