



## 2025 Wavemaker Fellowship Program Employer Endorsement Form

**Applicants:** Please have this form completed by your **Immediate Supervisor** to certify your current employment status at your company, performing work in a qualifying job field. Your employer should return the form to you, to be submitted with your application materials.

**Employers:** Please complete this form in its entirety to certify that you support your employee's eligibility for, and application to, the Wavemaker Fellowship Program. Questions? Visit [www.wavemaker.commerceri.com](http://www.wavemaker.commerceri.com) to review eligibility, or email [wavemaker@commerceri.com](mailto:wavemaker@commerceri.com) with questions.

### **ALL PERTINENT QUESTIONS MUST BE ANSWERED FOR ELIGIBILITY!**

#### **Wavemaker Applicant/Fellow Information: Fellow to Complete:**

1. Applicant/Fellow Legal Name: \_\_\_\_\_
2. Applicant/Fellow Job Title: \_\_\_\_\_
3. If applicable; have you held a **healthcare** job that did not require a degree in the past (**this applies to Healthcare fellows ONLY**) ☐ Yes ☐ No if 'Yes' please explain: \_\_\_\_\_
4. Are you bilingual? ☐ Yes ☐ No if 'Yes' please list Languages: \_\_\_\_\_

#### **Wavemaker Applicant/Fellow Information: Employer to Complete:**

5. Is this position considered a senior-level position at your company? ☐ Yes ☐ No
6. Does this position require specific skills/competencies that make it a **'Difficult to Fill'** position at your company? ☐ Yes ☐ No
7. Has the Applicant/Fellow worked for your company for the **ENTIRE** duration of their service period? ☐ Yes ☐ No  
If **'NO'** please provide duration of employment: \_\_\_\_\_
8. Is the applicant a full-time employee? ☐ Yes ☐ No

*For the purposes of this program, full-time is defined as being employed by a business for a minimum of at least 35 hours/week or rendering any other standard of service generally accepted by custom or practice as full-time employment, with wages subject to withholding.*



9. Are the applicant/fellow's wages subject to Rhode Island State income tax withholding? ☐ Yes ☐ No

\* If 'NO', does the applicant work in the healthcare field as a Sole Proprietorship, Single-Member LLC, or as a Partner in a Healthcare Service Partnership? Yes No

10. Does this employee currently work remotely, either in full or in part? ☐ Yes ☐ No

*If yes, is this employee's role specifically a Rhode Island-based position? (In other words, but for the ability for the employee to work remotely with the help of technology, would this person otherwise be reporting to an RI-based office or worksite?)* ☐ Yes ☐ No

11. Is the applicant/fellow the owner or sole proprietor of this company? ☐ Yes ☐ No

**\* Business' not a Sole Proprietorship MUST be registered with the RI Secretary of State's Office in order to be eligible for the program. \***

12. Has this applicant received any workplace awards or recognition (ex: performance awards, merit-based awards, employee of the month, etc.)? ☐ Yes ☐ No

*If yes, please list:* \_\_\_\_\_  
\_\_\_\_\_

13. Please indicate which job field applies to the work that the applicant does daily for your organization:

☐

Life, natural or environmental sciences

☐

Computer, information, or software technology

☐

Advanced mathematics or finance

☐

Engineering

☐

Medicine/Healthcare or medical device technology

☐

Industrial design or other commercially relevant design field

☐

Education/Teaching

14. Please give a short description of the applicant's regular duties & responsibilities:

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15. What is the applicant/fellow's **Total/Annual Compensated Salary?** \$ \_\_\_\_\_



## **TEACHER applicants ONLY!**

1. Is the applicant employed in a RI Local Educational Agency (LEA) or an accredited private school institution NOT PRE-K? (**this applies to Teacher applicants ONLY**)    ☐ Yes    ☐ No
  
2. Does the applicant work in any of the following positions (**this applies to Teacher applicants ONLY**):  
(*School Counselor, School Psychologist, School Social Worker, Speech and Language Pathologist, School Nurse Teacher, Reading Specialist, Mathematics Specialist, Instructional Leader, or Building or District Level Administrator*), **indicate and circle position above**.    ☐ Yes    ☐ No
  
3. Does the applicant work as a teacher in any of the following positions (**this applies to Teacher applicants ONLY**): *All Grades English as a Second Language or Bilingual Dual-Language?*    ☐ Yes    ☐ No
  
4. Does the applicant work as a teacher in any Special Education certificate area? (**this applies to Teacher applicants ONLY**):    ☐ Yes    ☐ No
  
5. Does the applicant work as a teacher in any of the following grade-level positions: Middle Grades (5-8) and Secondary Grades (7-12)? (**this applies to Teacher applicants ONLY**):    ☐ Yes    ☐ No
  
6. Does the applicant work as a teacher in any of the following content areas: Science, Technology, CTE, Arts, or Mathematics? (**this applies to Teacher applicants ONLY**):    ☐ Yes    ☐ No
  
7. Does the applicant work with an underserved population, such as children with disabilities, English learners, children experiencing homelessness, children and youth in foster care, migratory students, children who are incarcerated, and other underserved students (US Department of Education, 2022)? (**this applies to Teacher applicants ONLY**):    ☐ Yes    ☐ No
  
8. Does the applicant work in a school which receives Title I funds? (**this applies to Teacher applicants ONLY**):    ☐ Yes    ☐ No
  
9. Does the applicant work in a school located within RI's urban core, namely Burrillville, Central Falls, Chariho, Coventry, Exeter-West Greenwich, Foster, Gloster, Little Compton, New Shoreham, North Smithfield, Pawtucket, Ponagansett, Providence, Scituate, South Kingstown, Tiverton, and Woonsocket? (**this applies to Teacher applicants ONLY**): **\*Circle specific district listed above\***    ☐ Yes    ☐ No



### Employer Information:

16. Organization Legal Name: \_\_\_\_\_

17. Organization Address: \_\_\_\_\_

18. RI Tax ID #: \_\_\_\_\_

19. NAICS ID#: \_\_\_\_\_

20. If applicable; are you a Medicaid provider **(this applies to healthcare applicants ONLY)**: \_\_\_\_\_

21. If applicable; please provide HPSA ID# **(this applies to healthcare applicants ONLY)**: \_\_\_\_\_

22. Which **Industry or Sector** is your company a part of?

☐

Biomedical Innovation

☐

IT, Cyber, Data Analytics

☐

Defense, Shipbuilding, Maritime

☐

Advanced Business Services

☐

Design, Food, Custom Manufacturing

☐

Transportation, Distribution & Logistics

☐

Arts, Education, Hospitality & Tourism

☐

Offshore Wind

☐

Healthcare

☐

Other: \_\_\_\_\_

23. Please describe your company's primary work/function: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

24. Name of individual completing this form: \_\_\_\_\_

25. Are you the owner or sole proprietor of this business? \_\_\_\_\_

26. Title of individual completing this form: \_\_\_\_\_

27. Email address of individual completing this form: \_\_\_\_\_

28. Phone number of individual completing form: \_\_\_\_\_

29. How long have you been supervising this Applicant/Fellow? \_\_\_\_\_

### Optional Employer Information:

30. How many employees are there in your company? \_\_\_\_\_

31. If your company has multiple locations, how many employees in your RI location (s)? \_\_\_\_\_

32. Is your company's workforce primarily comprised of Rhode Island residents? ☐ Yes ☐ No

33. Does your company recruit primarily from Rhode Island institutions of higher education? ☐ Yes ☐ No

*If yes, which institutions?* \_\_\_\_\_



**Employer Certification:**

I (Applicant/Fellow Supervisor) hereby certify that the answers to all questions in this form are true to the best of my knowledge and belief.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_