|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Provider: | |  | | | | | | | | | | |
| Provider Staff: |  | | | | | | | | | | |
| Date of Report: | |  | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Employment Verification** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Client Name: | | |  | | | | | VR Counselor: | | |  | |
|  | | | | | | | |  | | | | |
| Date of Birth: | | |  | | | | | Employer Contact/Title: | | |  | |
|  | | | | | | | |  | | | | |
|  | | | | | | | |  | | | | |
| Employer: | | |  | | | | | Supervisor: | | |  | |
|  | | | | | | | |  | | | | |
| Employer Address: | | |  | | | | | Employer Phone: | | |  | |
|  | | |  | | | | |  | | | | |
|  | | | | | | | |  | | | | |
| Employment Start Date: | | | | |  | | | Hours Per  Week: | | |  | |
|  | | | | | | | |  | | | | |
| Job Title: | | |  | | | | | Wage at 90 Days: | | |  | |
|  | | | | | | | |  | | | | |
| Job Duties: | | |  | | | | | Date Successful Employment Outcome Achieved: | | | |  |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Fringe Benefits: | | | |  | None |  | Paid Vacation | |  | Paid Sick Leave | | |
|  | | | |  | Health / Dental / Vision Insurance | | | |  | Retirement | | |
|  | | | |  | Other: | | | | | | | |
|  | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | |
|  | | | | | | | | | | | | |

I, the service provider, certify that all services, as documented within; including dates and times, are accurate to the best of my knowledge.

|  |  |  |
| --- | --- | --- |
| First and Last Name (print): | Signature of Service Provider: | Date: |