|  |  |
| --- | --- |
| 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:      |