Reporting Month and Year:      

Vendor Company Name:

Vendor Representative’s Name:

VR Participant Name:

VR Counselor Name:

DVR Purchase Order #:

**Employment Information**

Starting Date of Employment (MM/DD/YYYY):

Full Time  Part Time

Employer’s Name:

Employer’s Address:

Employer’s Contact Person:

Employer’s Contact Person Job Title:

Employer’s Contact Phone Number or Email Address:

Does the VR Participant give consent for DVR to contact their Employer?  Yes  No

VR Participant Job Title:                        
VR Participant Job Duties:

VR Participant Rate of Pay for Position:        Per Hour  Annually

Frequency of Pay:  Weekly  Biweekly  Semimonthly  Other

Pay Range for this Position:

Work Hours Per Week:

VR Participant Job Modifications/Accommodations:

Benefits Available:  Yes  No

Medical/Health Insurance with Hospitalization:  Yes  No  N/A

Sick Leave:  Yes  No  N/A

Paid Vacation:  Yes  No  N/A

Pension Plan:  Yes  No  N/A

The VR Participant's wage and benefits are at a level paid to non-disabled individuals for the same or similar work.  Yes  No (if no, please explain):

***\*\*Submission of pay stub, offer letter, or other supporting documents that verify employment (wage, benefits, start date, etc.) is required\*\****

Supporting Documents included:  Pay Stub  Offer Letter  Other

**VR Participant’s Signature:** Date:

If the VR Participant’s signature is not obtained, include justification:

**Vendor Representative Signature:** Date:          