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: