

Rehabilitation Division

Client Name: _____ Case ID#: _____ Counselor: _____

Employer who issues the paycheck: _____

Employment site (name of company where work is completed if different from issuer of paycheck): _____

Address: _____

Supervisor: _____

Phone: _____

Start Date: (date client begins earning wages): _____

Rate of Pay: _____ hourly weekly monthly

Full Time Part Time (# of hours per week): _____

If part time: Set number of hours per week

Number of hours per week varies: **Min#** _____ **Max#** _____

Work Schedule: Varies by Week Regular Schedule (days and times): _____

Benefits: Health Insurance **If yes**, client eligible:

First Day Three Months Six Months N/A

Annual Leave Sick Leave Retirement Plan

Paid Holidays Other _____

Probationary Period: Three Months Six Months One Year N/A Other _____

Job Title: _____

Job Duties (attach job description or describe below): _____

Note: A copy of client pay stub (as soon as available) is required if employer signature is not obtained.

Client /Representative Signature _____ Date: _____

(Indicates client is in agreement with job as described above)

Employer Signature _____ Date: _____

Job Developer Signature _____ Date: _____

Please submit the completed form to the referring Rehabilitation Counselor at BVR