Rehabilitation Division

Nevada Vocational Rehabilitation

☐ **30 DAYS** ☐ **60 DAYS** ☐ **90 DAYS**

Client Name: ______ Counselor: ______

Employer/Address: ______

Supervisor/Manager: ______ Work Phone: ______

Job Title: ______

Rate of Pay: ______ Hours per Week: ______

Start Date: ______ Today's Date: ______

Explain any change that occurred in the past 30 days:

☐ Increase in Pay ______ ☐ Schedule: ______ ☐ Received Promotion: ______

☐ Quit: ______ ☐ Terminated: ______ ☐ Change in Benefits:______ ☐ Other: ______

Client/Representative Signature: ______ Date: ______

Job Developer Signature: ______ Date: ______

Supervisor/Employer Signature: ______ Date: ______

Consistent Contact is Required

Date	Time	Method	Spoke/Met	Result
		☐ Text/Email ☐ Telephone ☐ Job Site Visit ☐ Other:	☐ Employer ☐ Client ☐ Other:	
		☐ Text/Email ☐ Telephone ☐ Job Site Visit ☐ Other:	☐ Employer ☐ Client ☐ Other:	
		☐ Text/Email ☐ Telephone ☐ Job Site Visit ☐ Other:	☐ Employer ☐ Client ☐ Other:	
		☐ Text/Email ☐ Telephone ☐ Job Site Visit	☐ Employer ☐ Client	

		☐ Other:	☐ Other:	

List any issues or concerns that may need to be addressed:

Form and a copy of the client's most recent paystub (if this form is not signed by the employer) to be submitted with each bill for payment of successful employment progress. Please submit the completed form to the referring Rehabilitaiton Counselor