

EMPLOYMENT OUTCOME SURVEY

Date: _____

To: _____

To help ensure your success at work, we are seeking your feedback. Your response to this survey will provide information regarding your current job status and will be used to determine if additional assistance may be needed. After completing this survey, please sign, date and return as soon as possible in the enclosed self-addressed stamped envelope.

Name of Employer: _____

Address: _____

Work Phone: _____ Start Date: _____

Job Title/Position: _____

Wage Per Hour: _____ Hours Worked Per Week: _____

Will medical insurance be available to you? Yes No
If yes, when will benefits begin? _____

Overall, are you satisfied with your job? Yes No
***If no, please comment below.**

Do you feel you are performing well on the job? Yes No
***If no, please comment below.**

Comments: (you may also provide positive feedback regarding your job in this section)

Participant's Signature: _____ Date: _____

Thank you for your cooperation. Please contact me at, if you have any questions.

Rehabilitation Counselor's Signature & Phone Number

Date