Participant’s Name:

Case ID#:

Rehabilitation Counselor:

Vocational Goal:

Reporting Period:

Date of Report:

Contractor Name:

Contractor Company:

Contractor Contact Information:

**Services Provided (Check and submit one service per report):**

**\*Note: if more than one service is checked the report will be rejected and sent back for correction.**

**Must submit at least one report per month.**

Job Seeking Services

Resume Development

Advocacy

Tutoring

Non-Supported Employment

Supported Employment

Supported Employment Job Fit Analysis

Customized Employment

Job Coaching

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Specific Time - Start and End** | **Total Time** | **Type of Participant Contact** | **Methods, Activities, Tasks and Progress:** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Issues that arose this month or remain unresolved (health, behavior, transportation, child care, etc.):

Past issues that have improved or been resolved:

Contractor Signature:      Date:

Please submit the completed report to the Business Development Team at businessdevelopment@detr.nv.gov