

 **Job Placement Services**

**Check Appropriate Box:**

[ ]  **932X-Job Retention Services**

[ ]  **937X-Job Retention Services (Deaf Service)**

|  |  |  |
| --- | --- | --- |
| AV#: | (7 digits) | Click to enter |
| ACCES-VR ID#: | (6 digits) | Click to enter |
| CAMS ID #: | (10 digits) | Click to enter |

|  |  |  |  |
| --- | --- | --- | --- |
| VR District Office:  | Click to enter | Vendor: | Click to enter |
| VRC Name: | Click to enter | NYS Fiscal System ID: | Click to enter |
|  | Report Date: | Click to enter |

|  |  |  |  |
| --- | --- | --- | --- |
| Participant First Name: | Click to enter | Participant Last Name: | Click to enter |
| Participant Phone Number: | Click to enter |
| Participant Email Address: | Click to enter |

**Placement Information**

|  |  |
| --- | --- |
|  |  |
| **Job Title:** | Click to enter |
|  |  |
| **Business Name (Employer):** | Click to enter |
|  |  |
| **Business Address:** | Click to enter |
|  |  |
| **Start Date of Employment:** | Click to enter |
|  |  |
| **Date 90-day Retention:** | Click to enter |
|  |
| **Work Schedule/Hours:** | Click to enter |
|  |
| **Wages:** | Click to enter |
|  |
| **Essential Functions of the Position:** | Click to enter |
|  |  |  |  |  |  |  |
| **Medical Benefits:** |[ ]  Yes |[ ]  No |  |  |  |  |
|  |  |  |  |  |  |  |
| **Other Benefits:** | Click to enter |
|  |  |
| **Was this placement a direct result of Work-Readiness 3 Service?** |[ ]  Yes |[ ]  No |
|  |  |  |  |  |
| **Is the participant satisfied with employment and agreeable to case closure (with the understanding that future applications for ACCES-VR Services is an option if their employment situation changes)?** |[ ]  Yes |[ ]  No |
| If No, explain: | Click to enter |
|  |  |  |  |  |  |  |
| **Describe Retention Services Provided:** |
| Click to enter |
|  |  |
| **Comments/Other Information:** |
| Click to enter |
|  |

|  |
| --- |
| **I hereby certify that the information submitted on this report is true and correct.** |
|  |  | Click to enter |
| Qualified Staff Signature |  | Date |  |
| Click to enter |  | Click to enter |
| Printed Name |  |  | Title |  |
| Phone Number: | Click to enter |  | Email: | Click to enter |

**I hereby certify that the information submitted on this report is true and correct.**

|  |  |  |
| --- | --- | --- |
|  |  | Click to enter |
| Participant Signature |  | Date |  |
| Click to enter |  |
| Printed Name |  |  |