AV#:	(7 digits)
ACCES-VR ID#:	(6 digits)
CAMS ID #:	(10 digits)

Job Placement Services

Check Appropriate Box:

☐ **931X-Job Placement**

☐ **936X-Job Placement (Deaf Service)**

VR District Office:	Vendor:
VRC Name:	NYS Fiscal System ID:
	Report Date:

Participant First Name:	Participant Last Name:
Participant Phone Number:	
Participant Email Address:	

Placement Information (When available, please attach participant's employer hire letter)

Job Title:

Business Name (Employer):

Business Address:

Start Date of Employment:

First Three Days of Actual Work: 1. 2. 3.

Work Schedule/Hours:

Wages:

Job Duties:

Medical Benefits: ☐ Yes ☐ No

Other Benefits:

Comments/Other information: (If a prior 931X was completed please include that information)

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

Qualified Staff Signature | Date

Printed Name | Title

Phone Number: | Email:

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

Participant Signature | Date

Printed Name