

**Assistive Technology / Rehabilitation Technology**

**Assistive Technology / Rehabilitation Technology Training**

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| --- | --- |
| Authorization # | Enter AV #. |
| Aware Participant ID | Enter Aware Participant ID  |

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| VR District Office: Click arrow to select office. | Vendor: Click to enter Vendor Name |
| VRC Name: Click to enter.  | SFS Vendor ID: SFS Vendor ID. |
|  | Report Date: Click to enter a date. |

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

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| **Assistive Technology Training Details** |
|  **Number of Hours Authorized:** Enter number of units authorized **Number of Hours Used for this report:** Click here to enter number of units used ***Note:*** Unit = 1 Hour (20 Max) |
|  **Training Dates:** Click to enter dates of service for this report. |
|  **Training Location:** Enter Training Location |
|  **Employment Outcome:** Enter Employment Outcome (as noted in referral). |
|  **Please discuss the Assistive Technology that the customer is learning and the progress being**  **made throughout the training period:**Enter assistive technology description and evaluation of customer’s progress in training. |
|  **Additional Information and Recommendations:** Enter Recommendations here. |
|  **Was this report completed within 10 business days of the last service?** |
|  | [ ]  Yes  | [ ]  No  |
|  **If not, please explain:** Click here to enter text. |

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| **Completed By:** |  |  |
| Enter staff name here. |  | Enter staff title here. |
| Printed Name |  | Title |
| Phone: Enter phone number. |  | Email: Enter email. |