**VR-167X**

# Assistive Technology / Rehabilitation Technology

## Assistive Technology / Rehabilitation Technology Training

| | |
|---|---|
| Authorization # | |
| Aware Participant ID | |

| | |
|---|---|
| VR District Office: | Vendor: |
| VRC Name: | SFS Vendor ID: |
| | Report Date: |

| | |
|---|---|
| Customer First Name: | Customer Last Name: |
| Customer Phone Number: | |
| Customer Email Address: | |

| **Assistive Technology Training Details** |
|---|
| **Number of Hours Authorized:**<br><br>**Number of Hours Used for this report:**<br><br>***Note:*** Unit = 1 Hour (20 Max)<br><br>**Training Dates:**<br><br>**Training Location:**<br><br>**Employment Outcome:**<br><br>**Please discuss the Assistive Technology that the customer is learning and the progress being made throughout the training period:** |



Revised: 2/5/2024

**Additional Information and Recommendations:**

**Was this report completed within 10 business days of the last service?**

☐ Yes ☐ No

**If not, please explain:**

**Completed By:**

Printed Name

Title

Phone:

Email: