

**Check Appropriate Box:**

- ☐ 929X Job Seeking and Development      ☐ 935X Job Seeking and Development (Deaf)
- ☐ 931X Job Placement      ☐ 936X Job Placement (Deaf)

Authorization #	
Aware Participant ID	

VR District Office:	Vendor:
VRC Name:	SFS Vendor ID:
Month of Service:	Report Date:

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

Summarize the services provided during the report month: (Activities, number of contacts with the customer, level of customer participation, barriers addressed, and ongoing issues needed to be resolved)

Hours of service provided this report month:

**Note: Job placement requires a minimum of 10 hours of service monthly.**

## VR-JP-MPAR

<b>Business Contacts</b>		
<b>1.</b>		
Contact Date:	Business Name:	Person Contacted:
Contact Type:	Outcome of Contact	
Comments:		
<b>2.</b>		
Contact Date:	Business Name:	Person Contacted:
Contact Type:	Outcome of Contact	
Comments:		
<b>3.</b>		
Contact Date:	Business Name:	Person Contacted:
Contact Type:	Outcome of Contact	
Comments:		
<b>4.</b>		
Contact Date:	Business Name:	Person Contacted:
Contact Type:	Outcome of Contact	
Comments:		
<b>5.</b>		
Contact Date:	Business Name:	Person Contacted:
Contact Type:	Outcome of Contact	
Comments:		
<b>6.</b>		
Contact Date:	Business Name:	Person Contacted:
Contact Type:	Outcome of Contact	
Comments:		

## VR-JP-MPAR

<b>7</b>		
Contact Date:	Business Name:	Person Contacted:
Contact Type:	Outcome of Contact	
Comments:		
<b>8.</b>		
Contact Date:	Business Name:	Person Contacted:
Contact Type:	Outcome of Contact	
Comments:		
<b>9.</b>		
Contact Date:	Business Name:	Person Contacted:
Contact Type:	Outcome of Contact	
Comments:		
<b>10.</b>		
Contact Date:	Business Name:	Person Contacted:
Contact Type:	Outcome of Contact	
Comments:		
Please include any additional information or recommendations:		

**Completed By:**

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Printed Name

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Title

Phone:

Email: