DVR-12 Rev (6/92)

CABINET FOR WORKFORCE DEVELOPMENT
DEPARTMENT OF VOCATIONAL REHABILITATION

# EMPLOYMENT FOLLOW-UP

Dear _____

Please fill in this form and return it to this office at your earliest convenience. The information requested is very important in completing your case file. This information will be treated in strictest confidence. Your cooperation will be appreciated.

NAME OF YOUR EMPLOYER: _____

JOB CLASSIFICATION OR TITLE: _____

EXPLAIN THE REQUIREMENTS OF YOUR JOB: _____

_____

DATE BEGAN WORK: _____ AVERAGE WEEKLY WAGE: _____

If self-employed, so state, giving your average weekly income._____

_____

DESCRIBE PRESENT HEALTH CONDITION: _____

_____

REMARKS: _____

_____

Please Sign Here:_____ Date: _____

Address:_____

RETURN TO: