



EMPLOYMENT AND TRAINING STAFFING

Participant Name: _____ Date: _____

Case Number: _____ Provider: _____

SECTION A. (To be completed by the provider)

CURRENT ACTIVITIES

Work Activities/Assignment: _____

Worksite name and location: _____

Start Date in Activities/Assignment: _____ Workdays/hours: _____

Additional Activities (specify type, days and hours): _____

Progress/Level of participant engagement or Change: _____

SECTION B. (To be completed by the local office representative)

CASE STATUS

Remains Eligible for Participation

Participants earned income budgeted eff. _____ - eligible for job retention services from the provider.

Case canceled eff. _____ - remains eligible for job retention services.

Case canceled eff. _____ **not** eligible for services after this date.

SECTION C. (To be agreed upon by both the provider and the local office)

CASE STATUS

Change Work Activities/Assignment to _____

Change Work Schedule to _____

Remove from provider (Explain) _____

No changes requested at this review

The representatives below certify that the information completed above is correct.

Local Office Representative: _____ Date: _____

Provider Representative: _____ Date: _____