

Local office letterhead

Please complete this questionnaire and return it to this office.

Your Name: _____ Social Security #: _____

Home Phone: _____

Current Address: _____

Employment Information

Employer's and/or Company Name: _____

Employer's Complete Address: _____

Your Job Title/Position: _____

Supervisor's Name: _____

Hourly Wage: \$ _____ Hours Worked Per Week (average): _____

Medical Insurance on Job? Yes No

Eligible for Vacation and Sick Leave? Yes No

Health or Disability Insurance on Job? Yes No

Job Duties: _____

Date You Began Working: _____

Are you doing well performing the duties of your job? Yes No

Are you satisfied with your employment? Yes No

Do you need additional services to maintain your job? Yes No

Please Explain: _____

Your Signature: _____

Date: _____

Thank you

Counselor's Name