



**DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
EMPLOYMENT SPECIALIST APPLICATION**



Provider Information						
PROVIDER NAME:					PROVIDER NUMBER:	
PROVIDER CONTACT:					PHONE NUMBER:	
SERVICES ES WILL PROVIDE:	<input type="checkbox"/>	Employment Services	<input type="checkbox"/>	Supported Employment Services	<input type="checkbox"/>	OJT

Employee Information			
FIRST NAME		MI	LAST NAME
MAILING ADDRESS			
	CITY	STATE	ZIP CODE
EMAIL ADDRESS:			
PROVIDER NAME:			

Post-Secondary Education					
NAME OF SCHOOL	CITY, STATE	CREDIT HOURS EARNED		MAJOR/MINOR COURSE OF STUDY	TYPE OF DEGREE EARNED
		QTR	SEM		

Employment				
EMPLOYER				
ADDRESS				
PHONE NUMBER				
JOB TITLE				
LENGTH OF TIME	FROM		TO	
JOB DUTIES				
YOUR NAME IF DIFFERENT DURING EMPLOYMENT				
EMPLOYER				
ADDRESS				
PHONE NUMBER				
JOB TITLE				
LENGTH OF TIME	FROM		TO	
JOB DUTIES				
YOUR NAME IF DIFFERENT DURING EMPLOYMENT				
EMPLOYER				
ADDRESS				
PHONE NUMBER				
JOB TITLE				

LENGTH OF TIME	FROM		TO	
JOB DUTIES				
YOUR NAME IF DIFFERENT DURING EMPLOYMENT				
EMPLOYER				
ADDRESS				
PHONE NUMBER				
JOB TITLE				
LENGTH OF TIME	FROM		TO	
JOB DUTIES				
YOUR NAME IF DIFFERENT DURING EMPLOYMENT				

Volunteer Work

Please describe any volunteer work you've performed in the areas of; job placement, job coaching, counseling or working with persons with disabilities:

Transportation

If you will transporting VR Customers, please provide the following:

- Valid and Current Driver's License
- Valid and Current Vehicle Registration
- Valid and Current Automobile Insurance with minimum coverage of 50,000/100,000 unless Provider's Agency Insurance Coverage Include Automobile Liability which Covers any Automobile

Certification

I hereby certify that, to the best of my knowledge, the above information is correct. Omissions, falsifications, misstatements, or misrepresentations above may determine me unqualified to provide services to VR Customers of Vocational Rehabilitation. I hereby consent to the release of my employment history from any of the above mentioned employers to Vocational Rehabilitation.

Signature:

I hereby certify that I am am not a subcontractor or independent contractor of the above Provider. If I am a subcontractor or independent contractor of the Provider, I have attached the employment agreement between myself and the Provider. Failure to provide this information will result in the Provider being in violation of the Employment Services Contract held with Vocational Rehabilitation.

Signature: