FLORIDA DIVISION OF VOCATIONAL REHABILITATION
PRE-PLACEMENT TRAINING REPORT

Customer Name:	**Customer ID Number:**
Provider Name:	**Provider Phone Number:**
Referral Date:	**Referral Acceptance Date:**
Employment Goal as identified on the Individualized Plan of Employment:	
Name & Title of Person Conducting Training:	
THIS TRAINING REPORT IS FOR: ☐ **INITIAL 20 HOURS**	☐ **ADDITIONAL 20 HOURS**

Number of training hours reported must total at least twenty (20). A Pre-Placement Training Survey, signed by the Customer, must be attached to this report.

TRAINING DATES	TRAINING TOPICS	TRAINING TIME	NUMBER OF HOURS	SATISFACTORILY COMPLETED YES	NO
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
This Section is to be used by the Provider to include a narrative of the Customer's training experience and justification for an additional 20 (twenty) hours; if applicable.		**TOTAL HOURS**			

Provider Signature: _____ Date: _____

Customer Signature: _____ Date: _____