STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF VOCATIONAL REHABILITATION

Customer Internship Program
Employer Expense Worksheet

INTERN'S NAME		INTERNSHIP BEGIN DATE		END DATE

NUMBER OF EXPECTED WORK HOURS PER PAY PERIOD		HOURLY WAGE		NUMBER OF PAY PERIODS IN INTERNSHIP PERIOD	TOTAL ESTIMATED WAGES
	X	**$**	**X**		

Total estimated wages (from above)	**$**
Total estimated payroll expenses (taxes, workers compensation)	**$**
Other expense (describe):	**$**
Other expense (describe):	**$**
Other expense (describe):	**$**
Total employer expenses	**$**

EMPLOYER'S SIGNATURE	DATE	TELEPHONE NUMBER