STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF V OCATIONAL REHABILITATION

## Customer Internship Program

# Internship Evaluation

This evaluation is completed by the host employer at the end of the internship and must be presented to the DVR Customer before the last day.

| INTERN'S NAME | DATES OF INTERNSHIP | BEGIN DATE | END DATE |
|---|---|---|---|
| | | | |

| | YES | NO |
|---|---|---|
| 1. Were you satisfied with overall performance? | ☐ | ☐ |
| 2. If not, how could performance have been more satisfactory: | | |
| 3. Was the intern's attendance dependable? | ☐ | ☐ |
| 4. Did the intern get along well with you, their co-workers, and others? | ☐ | ☐ |
| 5. If not, please explain: | | |
| 6. Will you serve as a future job reference for the intern? | ☐ | ☐ |

| EMPLOYER'S SIGNATURE | DATE | TELEPHONE NUMBER |
|---|---|---|
| | | |