Washington State Department of Social & Health Services
DVR Division of Vocational Rehabilitation

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