



DVR Division of Vocational Rehabilitation

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 | X | HOURLY WAGE | X | NUMBER OF PAY PERIODS IN INTERNSHIP PERIOD | TOTAL ESTIMATED WAGES |
| | | \$ | | | |
| 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 |