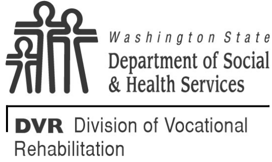

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF V OCATIONAL REHABILITATION

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