|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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 | | **X** | HOURLY WAGE | **X** | | NUMBER OF PAY PERIODS IN INTERNSHIP PERIOD | TOTAL EXTIMATED 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 |