EMPLOYMENT ATTENDANCE FORM

Notice Date: ____________
Case Name: ____________
Case Number: ____________
Worker Name: ____________
Worker Number: ____________
Telephone Number: ____________
Worker Hours: ____________
Address:

ADDRESSEE

This report is due by __________. If not received, your supportive services for transportation and / or child care may go down or stop.

Report Month: _________

Instructions:

- For each activity you are participating in, a separate Attendance and Progress Report needs to be completed unless your Employment Counselor tells you differently.
- If you have a change in schedule and/or fail to attend your activity you must tell us why in the "comments" section and attach proof on the reason for not attending. You must also list holidays and/or breaks that you did not go to work.
- Only enter information for days you are scheduled to work.
- You must attach proof reported participation hours, such as pay stubs, time sheets, or employer reports.

Part A – Participant Completes This Section

Name of Employer: ______________________ Job Title: ____________________________

Is this a new job? ☐ Yes ☐ No

See reverse side for additional information

Employment Monthly Attendance Form

Part B - Participant Completes This Section

Participant Name: ______________________ Phone #: ______________________
Case Number: ______________________ Worker Name/#: ______________________
Month / Year: ______________________ Activity: ______________________

Date	Day of Week	Total Hours Worked	Comments (Reason for Absence; Change in Schedule)	**County Use Only**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
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21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				

County Use Only:
Total Activity Hrs: _______ Total Excused Hrs: ________ Total Holiday Hrs: ________ Total Monthly Activity Hrs: ________

I certify under the penalty of perjury the above information is a true and accurate record. I understand that incorrect information may result in an overpayment of ancillary and/or supportive services, and I am responsible for repayment.

______________________________ ______________________
Participant Signature Date

______________________________ ______________________
Authorized Staff Signature and Date Authorized Staff Phone Number