



**Vocational Rehabilitation and Blind Services Programs (VRBS)
Montana Department of Public Health and Human Services**

Successful Outcome Form

Client Name: _____

Job Title: _____

Place of Employment: _____

Address of Employment: _____
Street City Zip

Start Date of Employment: _____

Supervisor/Manager Name and Contact Number: _____

Number of Hours worked per week: _____

Hourly Pay Rate: _____

Benefits Provided: _____

First pay stub included with form? _____

Employment Specialist Signature

Date