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|  |  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 |