DATE

NAME
ADDRESS
CITY, STATE, ZIP CODE

Dear NAME,

Federal regulations requires the Iowa Department for the Blind (IDB) to collect quarterly wage information from individuals who received services through the Iowa Self-Employment Program for each of the four quarters following case closure. The information is used to evaluate the IDB Vocational Rehabilitation program. Please provide the following information for the following timeframe:

Quarterly information for: MM/DD/YY through MM/DD/YY

Number of hours worked per week in the above-referenced timeframe: _____

Total wages earned during the above-referenced timeframe: $_____
Wages are based on Net Profit before Taxes (gross sales or revenue from your business, minus all legitimate deductible business expenses.)

FEIN or SSN under which the business operates: _____

Is the business still in operation? Yes or No

I declare that the information provided above, to the best of my knowledge, is accurate.

Your signature _____ Date: _____

Please complete and return to Lynnette Biermann in the enclosed envelope by MM/DD/YY. Thank you.

Sincerely,

Counselor
Counselor Contact Information