Promise Jobs
Promoting Independence and Self-Sufficiency through Employment
Job Opportunities and Basic Skills

The Department of Human Services in Partnership with the Departments of Economic Development, Education, Human Rights, Management, and Workforce Development.

TIME AND ATTENDANCE

Name: _____ Soc. Sec. No.: _____

Program: _____ Location: _____

Have you moved in the past month: ☐ Yes ☐ No New address: _____

Report Month _____ Year _____ New phone: _____

WEEK # 1	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
DATE								TOTAL
Hours Scheduled								
Hours Attended								
Study Hall Hours								

WEEK # 2	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
DATE								TOTAL
Hours Scheduled								
Hours Attended								
Study Hall Hours								

WEEK # 3	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
DATE								TOTAL
Hours Scheduled								
Hours Attended								
Study Hall Hours								

WEEK # 4	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
DATE								TOTAL
Hours Scheduled								
Hours Attended								
Study Hall Hours								

WEEK # 5	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
DATE								TOTAL
Hours Scheduled								
Hours Attended								
Study Hall Hours								

DO NOT WRITE IN THIS BOX

Component Code _____

Start Date _____

Recoupment _____

Please indicate participant progress below:

	Satisfactory	Needs Improvement	Unsatisfactory
Attendance:			
Quality of Work:			
Completion of Work:			

Overall this participant is making satisfactory progress: ❑ Yes ❑ No

Please identify any problems:

Authorized Signature:	Date:	Structured Study Hall Monitor Signature:	Date:

- You must notify your PROMISE JOBS worker before making any changes related to your training program.
- Return this form as soon as possible. You or your training provider must return it within 10 calendar days after the end of the month. If your training provider unexpectedly refuses or fails to complete this form, you must return it within 5 working days after your PROMISE JOBS worker asks you to complete it. Failure to return this form within these time frames or failure to report correct information may result in termination of your training plan or, in some cases, cancellation of your Family Investment Program (FIP) benefits.

I certify that the above information is accurate and complete.

Participant Signature	Date

Return to:

64-2617 (IWD)
470-2617 (Rev. 9/01)

White: Participant to return to the PROMISE JOBS unit when complete
Yellow: Participant or provider