

COMMUNITY SERVICE WORK VERIFICATION FORM
Non-Profit Organizations Only

FORM TO BE COMPLETED BY SUPERVISOR

Defendant's Name & Case Number: _____

Name of Non-Profit Organization: _____

Address of Non-Profit Organization: _____

Phone Number of Organization/Supervisor: _____

Printed Name of Supervisor: _____

Signature of Supervisor: _____

Date of Evaluation: _____

Please check the following boxes:

	Excellent	Above Avg	Average	Below Avg	Poor
Does he/she follow instructions?					
Does he/she produce quality work?					
Does his/her share of work?					
Is he/she punctual?					
Does he/she work well with others?					
Require minimal supervision or direction?					

Date	Task	Time IN	Time OUT	Total Hours

Total Hours Required to Work: 4