FLORIDA DIVISION OF VOCATIONAL REHABILITATION

CAREER CAMP STUDENT ROSTER

Student Name:	**Case ID:**
Provider Name: Michael Hearts Academy, Inc	**Provider Phone Number:** 407-223-0949
Name & Title of Person Conducting Camp:	
This camp was conducted: ☐ **Virtually**	☐ **In Person**

The student must sign this form on the last day of training attesting to their attendance on all dates and times listed on this roster.

Camp Dates	Camp Topics	Time In	Break	Time Out	Total Program Hours
Click Here to add more training events.		**Total Camp Hours**			

Student Signature: _____ Date:

I hereby attest, to the best of my knowledge, the above information is correct. VR reserves the right to suspend Provider registration if VR suspects the Provider has knowingly falsified this document, or otherwise engaged in fraudulent activity.

Provider Signature: _____ Date:

Provider Printed Name: _____ Date:

Additional Training Hours

The student must sign this form on the last day of training attesting to their attendance on all dates and times listed on this roster.					
Camp Dates	**Camp Topics**	**Time In**	**Break**	**Time Out**	**Total Program Hours**
Return to page 1	Enter Total Hours from page 1:				
Return to page 1		**Total Camp Hours**			

Student Signature: _____ Date:

I hereby attest, to the best of my knowledge, the above information is correct. VR reserves the right to suspend Provider registration if VR suspects the Provider has knowingly falsified this document, or otherwise engaged in fraudulent activity.

Provider Signature: _____ Date:

Provider Printed Name: _____ Date:

If you have any difficulty regarding accessibility of this form or any data fields, contact Vocational Rehabilitation: Vremploymentserviceproviders@vr.fldoe.org