## State of Georgia

## ABAWD VOLUNTEER WORK VERIFICATION FORM

-	County Department of Family and Children Services
Client Name Client ID #	Case Manager Name Case # Case Manager Phone# Case Manager Fax#
PART I: To be completed by ca	se manager to assign number of work activity hours require
	Work Activity Type
Comparable Workfare:	Required hours per month:
Participation Month:	1
PART II: To be completed by loca Organization Name	al organization staff after completion of work activity hours.
Organization Address	
Organization Phone#	
Volunteer Supervisor Name	
person named above is participating	g in a satisfactory manner Yes No(select one)
completed hours in the mont	th of/(month/year).
Printed Name of Volunteer Super	rvisor
Signature of Volunteer Superviso	or/Date