Transition Notification Referral for Vocational Rehabilitation Services

From:	School	
	Address	
	Phone	
	Responsible Local	
	Education Authority Staff	
То:	Local Rehabilitation Office	
	Address	
	Phone	
	ATTN: (Counselor Name)	
Student:	Name	
	Address	
	Phone	
	Social Security Number	
	Birth Date	
	Expected Date to complete	
	or exit school	
Notificati	on Accompanied by:	
		Signed release of information
		• Current IEP
		Current Three year evaluation
		• Psychological testing information as recent as age 16 if available.
	CONSENT FOR	R REFERRAL/RELEASE OF INFORMATION
Below is t Rehabilita vocationa	he signature authorization for ation Services. I hereby consen l rehabilitation planning.	to be referred for Vocational nt to the release of the information to be sent to Rehabilitation Services for
Signature * Signature	of Student re of Parent/Legal Guardian (i	DateDate
		ease provide address and phone number if different than the student's.
		·
Phone:		