

Local Office Letterhead  
Date

*Name/ Address of Doctor  
or Medical Office*

Re: *Consumer's Name*  
SSN: *Consumer's Social Security Number*

*Consumer's Name* has applied for vocational rehabilitation services to become employed in the competitive workforce. To assist us with eligibility determination and vocational planning, we would appreciate the following information:

1. What is the person's diagnosis or primary disability?
2. Describe any physical or mental limitations.
3. Have you advised this individual to limit his or her activities in any way?
4. Have you recommended any pending or additional treatment? (Please also note the last time you saw this person for a medical appointment.)
5. Is the condition stabilized so that this person can participate in an employment or training program?

I have enclosed a signed Release of Information form. I have also enclosed a State of Kansas Service Authorization that allows for a payment of \$20 for your time to complete the information requested. Please enclose your bill with your report.

If you need additional information regarding this request or vocational rehabilitation services, please call me at *phone* or e-mail me at *e-mail address*. Thank you for your assistance.

Sincerely,

Counselor's or Case Manager's Name

Enclosures  
cc: case file 1