Kansas Department of Social and Rehabilitation Services
Rehabilitation Services

Transition Notification
Referrals for Vocational Rehabilitation Services

From:	School	______________________
	Address	______________________
	Phone	______________________
	Responsible Local Education Authority Staff	______________________
To:	Local Rehabilitation Office	**Garden City SRS District Office**
	Address	**Department of Social and Rehabilitation Services** **1710 Palace Drive** **Garden City, KS 67846**
	Phone	**(620) 272-5959**
	ATTN: (Counselor Name)	**Attn: Sandy Miller**
Student:	Name	______________________
	Address	______________________
	Phone	______________________
	Social Security Number	______________________
	Birth Date	______________________
	Expected Date to Complete Or exit school	______________________

Notification Accompanied by:

* Signed release of information
* Current IEP
* Current three year evaluation
* Psychological testing information as recent as age 16 if available

CONSENT FOR REFERRAL/RELEASE OF INFORMATION

Below is the signature authorization for ____________________________ to be referred for Vocational Rehabilitation Services. I hereby consent to the release of the information to be sent to Rehabilitation Services for vocational rehabilitation planning.

Signature of Student ____ Date ____________________
*Signature of Parent/Legal Guardian (if appropriate) __________________________ Date _______

If signed by parentllegal guardian, please provide address and phone number if different than the student'

Address: ____
Phone: ____________________________________
Reasonable accommodations needed: ____