

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:

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 parent/legal guardian, please provide address and phone number if different than the student's.

Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reasonable accommodations needed: \_\_\_\_\_