

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. Dian Mullins**

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: _____

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 **Dodge City SRS District Office**
Address **Department of Social and Rehabilitation Services**
1509 Ave P
Dodge City, KS 67801
Phone **(620) 227-8508 ext. 233**
ATTN: (Counselor Name) **Attn: Patricia Winger**

Student: Name _____
Address _____
Phone _____
Social Security Number _____
Birth Date _____
Expected Date to Complete
Or exit school _____

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