CALIFORNIA STATE UNIVERSITY LONG BEACH
WORKABILITY IV REFERRAL FORM

Bob Murphy Access Center
1250 Bellflower Blvd, SSC 110
Long Beach, CA 90840-0108
Voice 562-985-5401
Fax 562-985-7183

WorkAbility IV Program
1250 Bellflower Blvd, BH 250
Long Beach, CA 90840-0108
Voice 562-985-8462
Fax 562-985-1641

Name: Contact Phone:

Address: City: Zip:

Student ID: E-Mail: Birth date:

Disability (1) (2)

Functional Limitations:

Class: Freshman Sophomore Junior Senior Graduate Student CSULB Grad

Major/Program: Employment Goal:

Authorization to Release and Request Confidential Information

I, the undersigned, hereby authorize the release of confidential information to and/or request of information from my records with the following offices and agencies:

1. **CSULB:**
   - Bob Murphy Access Center
   - Stephen Benson Program
   - WorkAbility IV (WAIV) Program
   - Career Development Center
   - Cashier's Office
   - University CMS
2. **California Department of Rehabilitation (DOR)**
3. **Other Agency or Individual:**

This authorization allows WAIV staff to share information and to discuss issues related to my disability, enrollment and academic status, data related to career services, job search and employment via fax, telephone, or email communication with the above agencies on an as needed basis as it relates to my registration with WAIV. I understand WAIV is required to keep my Department of Rehabilitation Counselor informed of my participation in the program and progress toward my employment goal. I understand that WAIV file documents and other written information pertinent to me will be kept confidential and maintained in the WAIV office. I also understand that selected information may be released without personal identification as data for mandatory federal and state reporting. This consent may be revoked by the undersigned at any time, except to the extent that action to obtain or release information has already been taken.

Signature: **Print Name:**

Date Signed: **Expiration Date:**

A photocopy or fax of this authorization shall be considered valid.

OFFICE USE ONLY

☐ **Referral from BMAC to DOR** ***OR*** ☐ **Referral from DOR to WAIV**

CSULB Staff Use

Referring staff name: Email:

DOR Office Use

DOR Counselor: Office:
Phone Number: Email:
Counselor Signature: Date:

WorkAbility IV must be provided the following referral packet:

- ☐ WorkAbility IV Referral Form
- ☐ Copy of Signed IPE
- ☐ DR260 Consent to Release and Obtain Information Form
- ☐ Medical Documentation
- ☐ DR222 VR Services Application ***or*** DR210 Enrollment for VR Services
- ☐ Authorizing Case Note

Participant must be coded to: WAIV CSU Long Beach 090