

Vocational Rehabilitation Referral Sheet

Name of School: _____

Student Name: _____

Birthdate: _____

Social Security Number if Known: _____

Address: _____

Student Phone Number: _____

Grade in School: _____

Date Referred: _____

Teacher of Record or Resource Room Teacher _____

Information included if applicable: _____

Referred by : _____

Referral Contact Number: _____

Please Mail this or Fax it to:

Vocational Rehabilitation
840 N Miller Ave. Suite C
Marion, IN 46952

Fax it to: 855-450-3572

Toll Free Number to Contact Vocational Rehabilitation: 877-876-2866

*I give permission for the school to provide my contact information to Vocational Rehabilitation