CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

DEPARTMENT OF REHABILITATION

WorkAbility IV
Application/Release Form
Phone: 909.537.7207 Email: WAIV@csusb.edu

Department of Rehabilitation Information:

Department of Rehabilitation Office: _____ Department of Rehabilitation Counselor: _____

Student Information:

Full Name: _____

Last Four of SS #: XXX-XX-____ ____ ____ ____ Coyote ID #: _____

Mailing Address: _____

City, State & Zip Code: _____

Phone Number: _____ Alternate Number: _____

CSUSB Email Address: _____

Alternate Email Address: _____

Degree Information:

Undergrad/Graduate Degree: _____ Major: _____ Anticipated Grad Date mo/yr: _____

Graduated Degree: _____ Major: _____ Actual Grad Date mo/yr: _____

I hereby consent to and authorize WorkAbility IV (WAIV) at California State University, San Bernardino to obtain my information from the State Department of Rehabilitation (DOR) regarding employment preparation, job development, and placement services.

I understand that the WAIV staff can exchange my student record information with DOR staff under FERPA regulations. I understand WAIV staff members include all staff as listed in the Workability IV Cooperative Program Contract.

I understand that this consent shall be valid for the period of time shown above, that I am actively supported by DOR, and/or currently matriculated at CSUSB, as cited in the WAIV contract.

I understand that I may revoke this consent to release information at any time in writing. I also understand that any release which has been made prior to my revocation and which was made based upon this authorization shall not constitute a breach of my right to confidentiality.

Signature: _____ Date: _____

Office Use Only	Intake received by:	Emailed Per Request of Student	Contract Year: 2015-2016

White: WAIV File Yellow: DOR Pink: Student