CALIFORNIA STATE UNIVERSITY SAN BERNARDINO

DEPARTMENT OF REHABILITATION
Employment, Independence & Equality

WorkAbility IV Release Form

5500 University Parkway, San Bernardino, CA 92407
Phone: 909.537.7207 Email: WAIV@csusb.edu

Full Name _____

Last Four of SS # XXX-XX-____ ____ ____ ____Coyote ID_____

Mailing Address _____

City, State & Zip_____

Phone_____ Home ☐ Work ☐ Cell ☐

Alternate Phone _____ Home ☐ Work ☐ Cell ☐

Date of Birth _____CSUSB Email_____@coyote.csusb.edu

Alternate Email _____

Who is your Department of Rehabilitation Counselor? _____

What Department of Rehabilitation Office are you with? _____

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 from my signature date through WorkAbility IV contract ending **June 30, 2020,** 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.

Parent/Guardian Signature_____ Date_____
(*required for minor*)

Signature _____**Date** _____

Office Use Only: Intake Staff signature:_____ **Date**_____

White: WAIV File Yellow: DOR Pink: Student