

WorkAbility IV Program Application

5500 University Parkway, San Bernardino, CA 92407

Phone: 909.537.7207 Email: WAIV@csusb.edu

General Information:

Full Name _____

Last Four of SS# _____ Coyote ID _____

Mailing Address _____

City, State & Zip _____

Preferred Phone _____ Home Work Cell

Alternate Phone _____ Home Work Cell

Date of Birth _____ CSUSB Email _____@coyote.csusb.edu

Preferred email _____

When do you expect to graduate? Quarter: _____ Year: _____

Major _____ Degree B.A. M.A.

Are you a client of the California Department of Rehabilitation (DOR)?

*Yes _____

Who is your Department of Rehabilitation Counselor? _____

What Department of Rehabilitation Office are you with? _____

No _____

Have you met with a DOR Representative?

Yes _____ Date _____ Representative _____

No _____

Are you a Veteran? Yes _____ No _____ Prefer not to disclose _____

****Please note as a client of DOR you are required to have a current WorkAbility IV Release Form on file in order to fully participate in the program.***

Parent/Guardian Signature _____ Date _____
(required for minor)

Signature _____ Date _____

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

White – Agency Canary – DOR Pink – Student