Referral for MD Work Transition Program at Four County Career Center

Name: _____ Age: _____ Birthdate: _____

Parent/Guardian: _____

Address: _____

Telephone: _____ Board of DD SSA: _____ Grade Level:_____

Primary Disability: _____

Secondary Disability: _____

School of Attendance: _____ Home School District: _____

Intervention Specialist: _____ Person Referring: _____

Will this student go through social graduation? Yes No If yes, what year? _____

Year Student Expects to Exit Special Education: _____

Name of Supervisor/Director of Special Education:_____

Is it your opinion that this student will need Job Training Services (Option IV) to transition into community-competitive employment? Yes No

Please attach the following reports/information: (*If receiving these services)

_____ ETR

_____IEP

_____Community Work Observations

_____Vocational Evaluation

_____Behavior Reports/Plans

***_____ Speech and Language Reports**

***_____ Physical Therapy Reports**

***_____ Occupational Therapy Reports**

***_____ Physical Development Reports**

_____Other