CRP DISABILITY CERTIFICATION FORM

1. CRP Name:____

2. Employee/Client Number:_______________
(assign a case number to each employee/client if none exists)

3. ☐ Full Time ☐ Part Time (less than 20 hours per week)

4. Entry/Hire Date:___/___/___ **5. Termination Date:**___/___/___

6. Position Held and Brief Summary of Work Performed:____________________________

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7. Referral or Evaluation Source:

☐ a. State, governmental or local social service agency (specify agency):____________________

☐ b. Vocational Rehabilitation Specialist (must complete accompanying Disability Determination Worksheet - DDW)

☐ c. Other referral source (specify type of documentation by completing Item 8 below)

8. CRP Supporting Documentation of Disability or Impairment on file:

☐ Medical Doctor Evaluation Form

☐ Psychiatrist Evaluation Form

☐ Psychologist Evaluation Form

☐ Ophthalmologist Examination Form

☐ Optometrist Examination Form

☐ Proof of Social Security Disability Insurance (SSDI) Benefit

☐ AbilityOne/JWOD Evaluation Form

☐ Other Professional Evaluation Form

9. Documentation of Disability: Indicate below how this employee/client qualifies for participation in the State Use Program.

☐ Referral from any of the sources in **Item 7a** above (with documentation on file) implies that the referral source listed made the determination that the disability impedes the individual from maintaining gainful employment.

☐ Disability determination from a Vocational Rehabilitation Specialist in **Item 7b** above must include a completed Disability Determination Worksheet (DDW) indicating that the disability impedes the individual from maintaining gainful employment.

☐ Disability determination from a recognized licensed professional or other source in **Item 7c** above should include the professional's determination that the disability impedes the individual from maintaining gainful employment.

I certify that to the best of my knowledge the information furnished on this form is accurate. I understand and acknowledge that the above representations are material and important and will be relied upon by the State of Texas in awarding State Use contracts.

______________________________________ ____________
Signature of CRP Director or Designee Date

____
Print Name and Title

Employee Disability Consent Form must be included in the file with this document. Attach additional pages if necessary. This is a confidential employee record of the CRP named above. The original copy is to be maintained at the CRP for review by the Texas Workforce Commission or its designee.

Chapter 122, Texas Human Resources Code
40 Texas Administrative Code, Part 20, Chapter 806
Texas Workforce Commission, Rule 806.41(e)(2)