WORKFORCE INVESTMENT ACT
DISABILITY VERIFICATION

IDENTIFYING INFORMATION

Applicant's Name: _____

Last **First** **MI**

SSN: _____ **Application Date:** _____

To Whom It May Concern:
In order to establish eligibility for training and employment under the Workforce Investment Act, verification of my disability is necessary. This is your authorization to release information acknowledging that I have a disability. Please complete this form as soon as possible as it is required before I can be determined eligible for the program. Your prompt return of this information is appreciated.

_____

Signature of Disabled Individual Date Signature of Parent/Guardian Date

FOR WIA ELIGIBILITY PURPOSES, AN INDIVIDUAL WITH A DISABILITY MEANS, ANY INDIVIDUAL WHO HAS A PHYSICAL OR MENTAL DISABILITY, WHICH FOR SUCH AN INDIVIDUAL CONSTITUTES OR RESULTS IN A SUBSTANTIAL HANDICAP TO EMPLOYMENT.

Individuals meeting this criterion can be certified disabled by an authorized agency or individual, ie. Texas Rehabilitation Commission, Mental Health and Mental Retardation, physician, other authorized professional, etc. (Individuals who are verified as having a disability must meet the general eligibility requirements for WIA certification.)

TO BE COMPLETED BY PHYSICIAN/PROFESSIONAL)

I certify that the individual identified above has been evaluated/tested/examined and has a disability as it is defined above.

Signature of Certifying Physician/Professional _____
Title Date

Name of Certifying Physician/Professional (Print/Type): _____

Name of Authorization Agency (Print/Type): _____

_____
Address City State Zip

Method Used to Evaluate/Determine Disability (Print/Type): _____
(Most Recent Evaluation or Testing Date)

PLEASE RETURN TO:
Contractor's Name: _____

Street Address: _____
City State Zip

Signature of WIA Counselor: _____ Date: _____