TN Department of Human Services

Pre-Employment Transition Services Permission

FIRST NAME	LAST NAME		MIDDLE NAME
SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RACE/ETHNICITY
ADDRESS			PHONE NUMBER (Include area code)
EMAIL ADDRESS			ALTERNATE CONTACT INFORAMTION

I hereby authorize the student listed above to participate in Pre-Employment Transition Services. I authorize the Local Education Agency to release Disability Certification information to the Department of Human Services, Vocational Rehabilitation Program (VR). I understand that this information will be treated in a confidential manner by VR and is not protected under the Health Insurance Portability and Accountability Act (HIPAA).

Participation in Pre-Employment Transition Services does not qualify this individual for Vocational Rehabilitation services.

Parent ☐ /Guardian ☐ /Adult Student ☐ Signature: Date:	Printed Name:

County	School