

SE Service Provider Name & Address:	Consumer:		Date:
	DOR Counselor:		DOR District:
	SEP#:	DOR Counselor Fax:	Individual Group

Consumer Job Choices: First:
 Second:
 Third:

Work Week Goal (Hours/Week):

Mon:	Tues:	Wed:	Thurs:	Fri:	Sat:	Sun:
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Days/Hours Available:
 (example 9am-10pm)

Preferred Location:

Location Restrictions:

Mode of Travel:

Travel Restrictions:


Comments:

FUNCTIONAL LIMITATIONS: Check all that apply

- | | |
|---|--|
| Mobility | Communication (i.e. hearing, seeing, speaking) |
| Self Care | Work Skills |
| Work Tolerance | Cognitive Restrictions (i.e. literacy) |
| Physical Restrictions | Medications/Side Effects |
| Environmental Considerations (i.e. Heights, Machinery, Direct Sunlight, Heat, Cold, Dust, etc.) | |
| Other (i.e. conditions of probation) Explain: | |

Specifics / Recommended Accommodation(s)

DOR Counselor Certification: I have discussed the above job placement parameters with the consumer and the SE Service Provider. The conditions are consistent with the IPE and the consumer's choices in Supported Employment.

DOR Counselor Signature: 	Email Address: @dor.ca.gov	Phone Number:	Date Signed:
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Distribution: Consumer SE Service Provider DOR Record of Services

NOTICE: This is confidential information from the records of the California Department of Rehabilitation. State and federal law and departmental regulations prohibit you from making any further disclosure of this information without the informed, written consent of the person to whom this information pertains.