EMPLOYEE DISABILITY CONSENT FORM

CRP Name: _____

Employee/Client Number: _____

I, _____ have reviewed the CRP Disability Certification Form
PRINT NAME
completed by my employer dated _____. I understand that I will be counted as person
CDF DATE
with a disability for purposes related to the State Use Program and requirements under Chapter 122, Texas Human Resources Codes.

_____ _____
SIGNATURE OF EMPLOYEE OR LEGAL REPRESENTATIVE DATE

If the authorization is signed by a Legal Representative of the Individual:

Printed name of Legal Representative: _____

Representative's authority to act for the Individual: _____

CRP Disability Certification Form must be included in the file with this document. 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)
7/21/17