# 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:**

_____

**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)
CRP DCF 7/21/17