

**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