EMPLOYEE DISABILITY CONSENT FORM

CRP Name: _____

Employee/Client Number: _____

I, _____ have reviewed the CRP Disability Determination
PRINT NAME

Documentation Cover Sheet (DIS-DOC-7/23) completed by my employer. I understand that I will be counted as a person 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 Determination Documentation Cover Sheet (DIS-DOC-7/23) 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 Resource Code
40 Texas Administrative Code, Part 20, Chapter 806
Texas Workforce Commission, Rule 806.41(e)(2)