WorkAbility IV Program Application

5500 University Parkway, San Bernardino, CA 92407
Phone: 909.537.7207 Email: WAIV@csusb.edu

General Information:

Full Name _____

Last Four of SS#____ ____ ____ ____ Coyote ID_____

Mailing Address_____

City, State & Zip_____

Preferred Phone_____ Home ☐ Work ☐ Cell ☐

Alternate Phone_____ Home ☐ Work ☐ Cell ☐

Date of Birth _____CSUSB Email_____@coyote.csusb.edu

Preferred email _____

When do you expect to graduate? Term: _____ Year: _____

Major _____ Degree B.A.☐ M.A.☐

Are you a client of the California Department of Rehabilitation (DOR)?

*Yes _____

Who is your Department of Rehabilitation Counselor? _____

What Department of Rehabilitation Office are you with? _____

No _____

Have you met with a DOR Representative?

Yes _____ Date _____ Representative _____

No _____

Are you a Veteran? Yes _____ No_____ Prefer not to disclose _____

Please note as a client of DOR you are required to have a current WorkAbility IV Release Form on file in order to fully participate in the program.

Parent/Guardian Signature _____ Date _____
(required for minor)

Signature _____ Date _____

Office Use Only: Intake Staff signature: _____Date:_____

White – Agency Canary – DOR Pink – Student