Occupational Skills Training

VA Vocational Rehabilitation Referral

2305 SE 82nd Ave, Portland OR 97216
Fax (971) 722- 6124 Phone (971) 722-6127

Date _____

STUDENT INFORMATION

Name _____ Claim # _____

Address _____ Phone _____

City _____ State _____ Zip _____ Cell _____

Email _____ Date of Birth: _____

Vocational Goal/Occupational Area _____ Length of Training _____

Functional Limitations: _____

_____

Accommodations: _____

_____

Legal History with Dates: _____

_____

TRAINING SITE (*If site has not been determined, please leave this section blank*)

Business/Agency Name _____

Trainer/POC _____ Email _____

Address _____ Phone _____

City _____ State _____ Zip _____ Fax _____

Start Date _____ End Date _____ Hours/Week _____

REFERRAL INFORMATION

Referring Counselor _____

Address _____ Phone _____

City _____ State _____ Zip _____ Cell _____

Email _____

Case Manager (if different from counselor) _____ Phone _____

Documents Included with Referral: ☐ 1905 (if site determined **only**) ☐ PCC Release ☐ Resume

☐ Other Documents _____