Revised 12/01/2001

COMMONWEALTH OF KENTUCKY
CABINET FOR WORKFORCE DEVELOPMENT
DEPARTMENT OF VOCATIONAL REHABILIATION
DEAF AND HARD OF HEARING SERVICE

REQUEST FOR INTERPRETER SERVICES

DATE OF REQUEST: _____

DATE OF SERVICE: _____ TIME: _____

CONTACT PERSON: _____ PHONE: _____

CUSTOMER NAME: _____

___ DVR STAFF
___ DVR CONSUMER
___ OTHER PLEASE SPECIFY _____

LOCATION OF SERVICE: PHONE: _____

_____

_____

_____

_____

SPECIAL INSTRUCTIONS OR DIRECTIONS:

_____

_____

_____

_____

COMMENTS: ____

____