CONFIDENTIAL REFERRAL FORM

Name:_____ **Date:**_____

Address:_____

City:_____ **State:**_____ **Zip code:**_____

Telephone #:_____ **Social Security #:**_____

Age:_____ **Sex:**_____ **DOB:**_____

Highest Grade of School Completed:_____

What is your Disability:_____

Are you physically able to come to this office? **Yes**_____ **NO** _____

Have you ever applied to DVRS before? **Yes**_____ **NO** _____

If Yes, where?_____ **When?**_____

Do you speak English? **Yes**_____ **NO** _____

Referred by:_____

Address:_____ **Telephone#:**_____

Completed forms can be accepted by any local DVRS location (click link below) or faxed to Central Office at (609) 292-8347. http://lwd.dol.state.nj.us/labor/dvrs/content/DVRSLocations.html