The Iris Network Rehabilitation Center
VRC Payor Authorization Form

This form to be completed by the referring VR Counselor. Please attach the most recent vision rehabilitation and other relevant reports.

Applicant's Name:

Applicant's Date of Birth:

Specific program goals:

Summary of previous vocational training:

Please list the desired vocational outcomes:

Please provide a baseline of current skills:

Please note any medical or health needs that may or will have a bearing on the applicant's participation in the program. Please keep in mind the structure and content of the program as well as the ability to live and dine in the community:

Printed Name of VR Counselor/Authorized Payor:

Signature of VR Counselor:

Date: