GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY
LANSING

SUSAN CORBIN
DIRECTOR

Michigan Rehabilitation Services
1184 Cleaver Rd. Suite 1000
Caro, MI 48723

Greetings,

Michigan Rehabilitation Services (MRS) helps students with disabilities prepare for life after high school. MRS works with eligible students who experience barriers to employment related to a physical, cognitive, or mental health impairment or diagnosis. MRS counselors work with students to explore their strengths, interests, and career goals and to prepare for employment, college, vocational training, or other plans after high school. Students with disabilities who may benefit from support with career exploration or employment preparation are encouraged to apply for our services.

Enclosed is the MRS application, along with the release of information and consent forms required to begin services. Please ensure that you have your student's social security number to complete the application and releases in full. An application can also be completed online at https://app.leo.state.mi.us/mrs/apply/.

Once the application is received, an MRS counselor will contact the student and/or family to schedule an intake appointment. During this meeting, the counselor will learn more about the student, discuss their career goals, explain the MRS process, and review the student's rights and responsibilities. MRS works closely with students, families, and schools to create an individualized plan that supports each student's goals and helps them successfully transition from high school to their next step.

If you have questions about MRS services or the application process, please reach out to the Tuscola County MRS office at (989) 673-7793. We are happy to help and look forward to working with you and your student.

Sincerely,

Taylor Post
Vocational Rehabilitation Counselor
517-262-3219
PostT2@michigan.gov

# APPLICATION FOR VOCATIONAL AND EMPLOYMENT SERVICES

Michigan Department of Labor and Economic Opportunity
Michigan Rehabilitation Services

| For MRS office use only<br>Date Application received |
|---|
| |

| **Personal Information** | | |
|---|---|---|
| Last Name: | First Name: | Middle Name: |
| Name you want to be called: | Former Last Name (if applicable): | Social Security Number: |
| Birth Date: | Gender: ☐ Male ☐ Female ☐ Non-binary or Another Gender ☐ Prefer Not to Answer | |
| Mailing Address: | | |
| City: | State: | Zip Code: |
| County: | Email Address: | |
| Primary Phone: (____) _____-_____ ☐ Voice ☐ TTY ☐ Fax ☐ Cell ☐ Video Phone | | |
| Secondary Phone: (____) _____-_____ ☐ Voice ☐ TTY ☐ Fax ☐ Cell ☐ Video Phone | | |
| What is your race/ethnicity (check all that apply)<br>☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Arab ☐ Asian<br>☐ Hmong ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander | | |
| Do you consider yourself to be multi-racial?<br>☐ Yes ☐ No | Are you a veteran?<br>☐ Yes ☐ No | |
| Were you a customer of MRS in the past?<br>☐ Yes ☐ No | When? | What Office? |
| Have you received Pre-Employment Transition Services (Pre-ETS) from MRS in the past?<br>☐ Yes ☐ No | When? | What Office? |
| **Your Needs** | | |
| What language do you use most of the time?<br>☐ English ☐ Spanish ☐ Arabic ☐ American Sign Language<br>☐ Other – Explain: | | |
| What language do you use for printed documents?<br>☐ English ☐ Spanish ☐ Arabic ☐ Other Explain: | | |
| Do you need an interpreter, large print or other type of help to work with MRS?<br>☐ Yes ☐ No Explain: | | |
| **Characteristics** | | |
| Do you have a:<br>• Legal Guardian<br>• Michigan Driver's License<br>• State of Michigan ID<br>• Work Permit | <br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No | **Copy of guardianship documents is required.**<br><br><br>Type of Permit: |

Customer Name _____

**Characteristics** *(continued)*

Marital status: ☐ Single/Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Are you a registered voter? ☐ Yes ☐ No Would you like to register to vote? ☐ Yes ☐ No

| | | |
|---|---|---|
| Are you a citizen of the U.S.? | ☐ Yes ☐ No | |
| If no, do you have a work Visa? | ☐ Yes ☐ No | **Please bring to your first appointment** |

**Disability Information**

| What is your physical or mental disability? (Examples: Depression, anxiety, substance abuse, learning disability, ADD, ADHD, cerebral palsy, arthritis, etc.) | Primary or Main | Secondary or Other Disability |
|---|---|---|

Does your disability affect your ability to:

☐ Stand ☐ Walk ☐ Sit ☐ Lift ☐ Bend
☐ See ☐ Hear ☐ Read ☐ Write ☐ Use Hands or Feet
☐ Concentrate ☐ Remember ☐ Learn ☐ Understand ☐ Handle Stress
☐ Communicate ☐ Control Emotions ☐ Work with Others
☐ Other – Explain:

**Basic Information**

What is your current living arrangement?

☐ Adult/Youth correctional facility
☐ Community residential/Group home
☐ Halfway house
☐ Homeless/shelter
☐ Mental health facility
☐ Nursing home
☐ Private residence (applicant only, with family or with another person)
☐ Rehabilitation Facility
☐ Substance abuse treatment center
☐ Other:

What is your current medical coverage? (Please check all that apply.)

☐ Medicaid ☐ Medicare ☐ Affordable Care Act ☐ None
☐ Private insurance through own employment Provider:
☐ Not yet eligible for private insurance through current employer
☐ Private insurance from other means (Example: insurance is provided by a parent or a spouse.)
Name of Insurance Company:
☐ Public Insurance from another source.
Name of Insurance Company:

| Are you currently enrolled in school? ☐ Yes ☐ No | If yes, what is your expected graduation date? |
|---|---|

How did you hear about MRS (referred by)?

**Income**

What is your primary source of income?

☐ Personal income (employment earnings, interest dividends, rent, retirement including Social Security)
☐ Public Support (SSI, SSDI, TANF, etc.) Explain:
☐ Family and friends ☐ Private Relief Agency ☐ Public Institution – Tax Supported
☐ Worker's Compensation
☐ All other sources (e.g., private disability insurance and private charities)

Customer Name _____

| *(Please check Yes or No and enter monthly amount, if applicable)* | | | |
|---|---|---|---|
| **Do you receive:** | **Yes (√)** | **No (√)** | **Monthly Amount** |
| Social Security Disability Insurance (SSDI) | ☐ | ☐ | |
| Supplemental Security Income (SSI) | ☐ | ☐ | |
| Family Independence Program (FIP) also known as Temporary Assistance to Needy Families (TANF) | ☐ | ☐ | |
| If yes, will you run out of TANF within 2 years? | ☐ | ☐ | |
| State Disability Assistance (SDA) also known as General Assistance (GA) in some areas | ☐ | ☐ | |
| Unemployment Insurance Benefits | ☐ | ☐ | |
| Veterans Disability (VA) | ☐ | ☐ | |
| Workers' Compensation | ☐ | ☐ | |
| Other types of Public Assistance (Examples: government payments for retirement or survivor benefits, Aid for Dependent Children, etc.) | ☐ | ☐ | |
| Other Disability Income:<br>☐ Long Term Disability (LTD) ☐ Auto No-Fault | ☐ | ☐ | |
| Non-Cash Income – Food Assistance (also known as Bridge Card) | ☐ | ☐ | |

I understand that:

- The purpose of receiving vocational rehabilitation services is to help me get or keep a job.
- I must be found eligible for the services that I require.
- The Social Security Administration may give MRS all information necessary to determine my eligibility and verify my identity.
- MRS may contact me during or after my case has been closed to provide an opportunity to share my experience about the program.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Parent or Legal Guardian, if applicable Date

The application has been reviewed and their rights and responsibilities have been discussed.

_____ _____

Signature (MRS Staff Member) Date

# INFORMATION REQUEST
# AUTHORIZATION TO RELEASE PERSONAL INFORMATION

Michigan Department of Labor and Economic Opportunity
Michigan Rehabilitation Services

*[For Office Use Only]*
Counselor Name

I, _____ , authorize the release of information from
*(Customer name, date of birth, and last 4 digits of Social Security Number)*

Tuscola ISD , or its director, designee, or records department to:
*(Hospital, clinic, agency, school or individual)*

MRS Office: 1184 Cleaver Rd., Suite 800, Caro, MI 48723
*(MRS office address)*

**NOTICE**: The Administrative Simplification provisions in Subtitle F of Title II under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and in 45 CFR Parts 160 and 162 – do not apply to State Vocational Rehabilitation Agencies.

**Specific type(s) of information to be disclosed:**

- ☑ Medical and psychological records for physical and/or mental illness
  - ☑ Discharge Summary ☑ Medications ☑ Assessment ☑ History and Physical
  - ☑ Diagnosis ☑ Treatment Plan Record ☑ Other (specify): IEP, REED or Psychological Repor
- ☐ Alcohol and drug abuse treatment information protected under the regulations in Title 42 of Federal Regulations Part II
- ☑ Academic, Vocational, and/or Special Education information
- ☐ Information about Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or other communicable and severe communicable diseases as defined by Public Act 174 of 1989.
- ☑ Other (specify): Any documentation related to disability

**The purpose(s) and need for such disclosure:**

- ☑ Establish eligibility for vocational rehabilitation services.
- ☑ Determine need for and/or type of treatment or accommodation as needed by the customer.
- ☑ Develop and carry out vocational rehabilitation planning.
- ☐ Other (specify): _____

- I understand that, in order to accomplish the above need for disclosure, it may be necessary for Michigan Rehabilitation Services (MRS) to share my records with others. I grant MRS permission to do so except for records that can only be legally released if I sign a separate written consent. I understand this permission to release information includes any follow-up written or verbal exchange needed to carry out the purpose of the disclosure with the above referenced hospital, clinic, agency, school or individual.
- I understand that, under federal law, I can have access to information in my case file (34 CFR 361.38), except:
  a. If the file contains medical, psychological, or other information that may be harmful to me, it may only be released to an appropriately identified third party.
  b. If the file contains personal information obtained from another source, it may only be released under the conditions established by the source that has provided the information to MRS.
- I understand that, under the Rehabilitation Act, personal information obtained from another source may only be re-released under the conditions established by the source that has provided the information to MRS.
- I understand that I can refuse to give permission for MRS to obtain information about me from other sources. However, I also understand that if my refusal results in MRS being unable to determine my eligibility or my refusal unreasonably interferes with my vocational program, my case may be delayed or closed.
- I understand that I may revoke the consent provided in this form at any time, by providing MRS with a signed and dated written notice. My consent shall remain valid for so long as I am an active customer of MRS unless otherwise specified below.

☐ If this box is initialed, my consent expires upon the following:
Date _____ Or Event _____

| Customer's Signature | | Date |
|---|---|---|
| Parent's or Legal Guardian's Signature, if applicable | Relationship | Date |

**Mailing Instructions:** Print copy of signed release for customer file, mail original to hospital, clinic, agency, school or individual.

The Michigan Department of Labor and Economic Opportunity (LEO) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

# INFORMATION REQUEST
# AUTHORIZATION TO RELEASE PERSONAL INFORMATION

Michigan Department of Labor and Economic Opportunity
Michigan Rehabilitation Services

| *[For Office Use Only]* |
|---|
| Counselor Name |

I, _____ , authorize the release of information from
*(Customer name, date of birth, and last 4 digits of Social Security Number)*

Do-All , or its director, designee, or records department to:
*(Hospital, clinic, agency, school or individual)*

1184 Cleaver Rd. Suite 1000 Caro, MI 48723
*(MRS office address)*

**NOTICE**: The Administrative Simplification provisions in Subtitle F of Title II under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and in 45 CFR Parts 160 and 162 – do not apply to State Vocational Rehabilitation Agencies.

**Specific type(s) of information to be disclosed:**

- ☐ Medical and psychological records for physical and/or mental illness
  - ☐ Discharge Summary ☐ Medications ☐ Assessment ☐ History and Physical
  - ☑ Diagnosis ☐ Treatment Plan Record ☐ Other (specify): _____
- ☐ Alcohol and drug abuse treatment information protected under the regulations in Title 42 of Federal Regulations Part II
- ☐ Academic, Vocational, and/or Special Education information
- ☐ Information about Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or other communicable and severe communicable diseases as defined by Public Act 174 of 1989.
- ☑ Other (specify): Name, birth date, address, phone, disability information

**The purpose(s) and need for such disclosure:**

- ☑ Establish eligibility for vocational rehabilitation services.
- ☑ Determine need for and/or type of treatment or accommodation as needed by the customer.
- ☑ Develop and carry out vocational rehabilitation planning.
- ☐ Other (specify): _____

- I understand that, in order to accomplish the above need for disclosure, it may be necessary for Michigan Rehabilitation Services (MRS) to share my records with others. I grant MRS permission to do so except for records that can only be legally released if I sign a separate written consent. I understand this permission to release information includes any follow-up written or verbal exchange needed to carry out the purpose of the disclosure with the above referenced hospital, clinic, agency, school or individual.
- I understand that, under federal law, I can have access to information in my case file (34 CFR 361.38), except:
  a. If the file contains medical, psychological, or other information that may be harmful to me, it may only be released to an appropriately identified third party.
  b. If the file contains personal information obtained from another source, it may only be released under the conditions established by the source that has provided the information to MRS.
- I understand that, under the Rehabilitation Act, personal information obtained from another source may only be re-released under the conditions established by the source that has provided the information to MRS.
- I understand that I can refuse to give permission for MRS to obtain information about me from other sources. However, I also understand that if my refusal results in MRS being unable to determine my eligibility or my refusal unreasonably interferes with my vocational program, my case may be delayed or closed.
- I understand that I may revoke the consent provided in this form at any time, by providing MRS with a signed and dated written notice. My consent shall remain valid for so long as I am an active customer of MRS unless otherwise specified below.

☐ If this box is initialed, my consent expires upon the following:
Date _____ Or Event MRS case closure

| Customer's Signature | | Date |
|---|---|---|
| Parent's or Legal Guardian's Signature, if applicable | Relationship | Date |

**Mailing Instructions:** Print copy of signed release for customer file, mail original to hospital, clinic, agency, school or individual.

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# INFORMATION REQUEST
# AUTHORIZATION TO RELEASE PERSONAL INFORMATION

Michigan Department of Labor and Economic Opportunity
Michigan Rehabilitation Services

| *[For Office Use Only]* |
|---|
| Counselor Name |

I, _____ , authorize the release of information from
*(Customer name, date of birth, and last 4 digits of Social Security Number)*

The Disability Network/Disability Network of Eastern Michigan , or its director, designee, or records department to:
*(Hospital, clinic, agency, school or individual)*

1184 Cleaver Rd. Suite 1000 Caro, MI 48723
*(MRS office address)*

**NOTICE**: The Administrative Simplification provisions in Subtitle F of Title II under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and in 45 CFR Parts 160 and 162 – do not apply to State Vocational Rehabilitation Agencies.

**Specific type(s) of information to be disclosed:**

- ☐ Medical and psychological records for physical and/or mental illness
  - ☐ Discharge Summary ☐ Medications ☐ Assessment ☐ History and Physical
  - ☑ Diagnosis ☐ Treatment Plan Record ☐ Other (specify): _____
- ☐ Alcohol and drug abuse treatment information protected under the regulations in Title 42 of Federal Regulations Part II
- ☐ Academic, Vocational, and/or Special Education information
- ☐ Information about Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or other communicable and severe communicable diseases as defined by Public Act 174 of 1989.
- ☑ Other (specify): Name, birth date, address, phone, and disability information to facilitate services

**The purpose(s) and need for such disclosure:**

- ☑ Establish eligibility for vocational rehabilitation services.
- ☑ Determine need for and/or type of treatment or accommodation as needed by the customer.
- ☑ Develop and carry out vocational rehabilitation planning.
- ☐ Other (specify): _____

- I understand that, in order to accomplish the above need for disclosure, it may be necessary for Michigan Rehabilitation Services (MRS) to share my records with others. I grant MRS permission to do so except for records that can only be legally released if I sign a separate written consent. I understand this permission to release information includes any follow-up written or verbal exchange needed to carry out the purpose of the disclosure with the above referenced hospital, clinic, agency, school or individual.
- I understand that, under federal law, I can have access to information in my case file (34 CFR 361.38), except:
  a. If the file contains medical, psychological, or other information that may be harmful to me, it may only be released to an appropriately identified third party.
  b. If the file contains personal information obtained from another source, it may only be released under the conditions established by the source that has provided the information to MRS.
- I understand that, under the Rehabilitation Act, personal information obtained from another source may only be re-released under the conditions established by the source that has provided the information to MRS.
- I understand that I can refuse to give permission for MRS to obtain information about me from other sources. However, I also understand that if my refusal results in MRS being unable to determine my eligibility or my refusal unreasonably interferes with my vocational program, my case may be delayed or closed.
- I understand that I may revoke the consent provided in this form at any time, by providing MRS with a signed and dated written notice. My consent shall remain valid for so long as I am an active customer of MRS unless otherwise specified below.

☐ If this box is initialed, my consent expires upon the following:
Date _____ Or Event MRS case closure

| Customer's Signature | | Date |
|---|---|---|
| Parent's or Legal Guardian's Signature, if applicable | Relationship | Date |

**Mailing Instructions:** Print copy of signed release for customer file, mail original to hospital, clinic, agency, school or individual.

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# CONSENT TO RELEASE PERSONAL INFORMATION

Michigan Department of Labor and Economic Opportunity
Michigan Rehabilitation Services

I, _____
(Customer's Name) (Birthday) (last 4 digits of Social Security Number)

**give my consent to Michigan Rehabilitation Services to release the following information or records, except where prohibited by law, for purposes directly connected to my vocational rehabilitation.**

- [x] Information about my disability, including if applicable, information regarding alcohol and drug abuse protected under 42 CFR, Part 2.
- [ ] Records regarding the diagnosis and treatment of HIV/AIDS or other communicable diseases defined by Public Act 174 of 1989.
- [x] Medical Records
- [x] Results of a work evaluation; results of a skill aptitude, or achievement tests; or reports regarding my performance in a training program.
- [ ] Accommodation prescriptions and recommendations.
- [ ] Case notes.
- [x] Other (describe): IEP, REED, or psychological report or any documents related to disability

**This information may be released to:**

- [ ] Any employers Michigan Rehabilitation Services may contact on my behalf.
- [x] The following organization, individual, or specific employer: Tuscola ISD

**The purpose of this release is for:**

- [x] Conducting an assessment or evaluation
- [x] Aiding my participation in training
- [x] Helping me develop or maintain a job
- [ ] Other (describe): _____
- [x] Planning Accommodations
- [x] Providing Treatment
- [x] Providing Equipment

**This consent to release personal information is valid until the date, event, or condition I describe below.**

MRS case closure
(Event, Condition or Expiration Date)

I may revoke this authorization in writing except to the extent that action has been taken in reliance on it. I also understand that I am not required to sign this release, but by doing so I can help myself get the services I need.

| Customer Signature | Date |
|---|---|
| Parent or Guardian Signature (Where Required) | Date |

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# CONSENT TO RELEASE PERSONAL INFORMATION

Michigan Department of Labor and Economic Opportunity
Michigan Rehabilitation Services

I, _____
(Customer's Name) (Birthday) (last 4 digits of Social Security Number)

**give my consent to Michigan Rehabilitation Services to release the following information or records, except where prohibited by law, for purposes directly connected to my vocational rehabilitation.**

☑ Information about my disability, including if applicable, information regarding alcohol and drug abuse protected under 42 CFR, Part 2.

☐ Records regarding the diagnosis and treatment of HIV/AIDS or other communicable diseases defined by Public Act 174 of 1989.

☐ Medical Records

☐ Results of a work evaluation; results of a skill aptitude, or achievement tests; or reports regarding my performance in a training program.

☐ Accommodation prescriptions and recommendations.

☐ Case notes.

☑ Other (describe): Name, Birth Date, Address, Phone, Disability Information

**This information may be released to:**

☐ Any employers Michigan Rehabilitation Services may contact on my behalf.

☑ The following organization, individual, or specific employer: Do-All

**The purpose of this release is for:**

☑ Conducting an assessment or evaluation ☐ Planning Accommodations

☐ Aiding my participation in training ☐ Providing Treatment

☑ Helping me develop or maintain a job ☐ Providing Equipment

☑ Other (describe): Referral Information to Facilitate Services

**This consent to release personal information is valid until the date, event, or condition I describe below.**

Case Closure
(Event, Condition or Expiration Date)

I may revoke this authorization in writing except to the extent that action has been taken in reliance on it. I also understand that I am not required to sign this release, but by doing so I can help myself get the services I need.

| Customer Signature | Date |
|---|---|
| Parent or Guardian Signature (Where Required) | Date |

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# CONSENT TO RELEASE PERSONAL INFORMATION

Michigan Department of Labor and Economic Opportunity
Michigan Rehabilitation Services

I, _____
(Customer's Name) (Birthday) (last 4 digits of Social Security Number)

**give my consent to Michigan Rehabilitation Services to release the following information or records, except where prohibited by law, for purposes directly connected to my vocational rehabilitation.**

- [x] Information about my disability, including if applicable, information regarding alcohol and drug abuse protected under 42 CFR, Part 2.
- [ ] Records regarding the diagnosis and treatment of HIV/AIDS or other communicable diseases defined by Public Act 174 of 1989.
- [ ] Medical Records
- [ ] Results of a work evaluation; results of a skill aptitude, or achievement tests; or reports regarding my performance in a training program.
- [ ] Accommodation prescriptions and recommendations.
- [ ] Case notes.
- [x] Other (describe): Name, Birth Date, Address, Phone, Disability Information

**This information may be released to:**

- [ ] Any employers Michigan Rehabilitation Services may contact on my behalf.
- [x] The following organization, individual, or specific employer: TDN/DNEM

**The purpose of this release is for:**

- [x] Conducting an assessment or evaluation
- [ ] Aiding my participation in training
- [x] Helping me develop or maintain a job
- [x] Other (describe): Referral Information to Facilitate Services
- [ ] Planning Accommodations
- [ ] Providing Treatment
- [ ] Providing Equipment

**This consent to release personal information is valid until the date, event, or condition I describe below.**

Case Closure
(Event, Condition or Expiration Date)

I may revoke this authorization in writing except to the extent that action has been taken in reliance on it. I also understand that I am not required to sign this release, but by doing so I can help myself get the services I need.

| Customer Signature | Date |
|---|---|
| Parent or Guardian Signature (Where Required) | Date |

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# CONSENT TO RELEASE PERSONAL INFORMATION TO OBTAIN ACADEMIC RECORDS

Michigan Department of Labor and Economic Opportunity
Michigan Rehabilitation Services

I, _____
(Customer's Name) (Birthday) (Last 4 digits of Social Security Number)

**1. Give my consent to Parchment to obtain academic records and transcripts, including but not limited to records containing my grades/GPA, registration, student ID number, academic progress reports, enrollment status, number of credit hours enrolled in, and courses enrolled in from:**

| |
|---|
| |

**2. Give my consent for Parchment to release obtained academic records and school transcripts to Michigan Rehabilitation Services**

**The purpose of this information is to document academic progress in alignment with VR services.**

- I understand this permission to release information includes any follow-up written or verbal exchange needed to carry out the purpose of the disclosure with the above referenced business and school.
- I understand that, under federal law, I can have access to information in my case file (34 CFR 361.38), except: a. If the file contains medical, psychological, or other information that may be harmful to me, it may only be released to an appropriately identified third party. b. If the file contains personal information obtained from another source, it may only be released under the conditions established by the source that has provided the information to MRS.
- I understand that, under the Rehabilitation Act, 29 USC 701, et seq., personal information obtained by MRS from another source may only be re-released under the conditions set by the source that provided the information to MRS.
- I understand that I can refuse to give permission for MRS to obtain information about me from other sources. However, I also understand that if my refusal results in MRS being unable to verify my school status, my case may be delayed or closed.
- I understand that I may revoke the consent provided in this form at any time, by providing MRS with a signed and dated written notice.
- My consent shall remain valid for so long as I am an active customer of MRS or until terminated in writing.

| Customer Signature | Date |
|---|---|
| Parent or Guardian Name (Where Required) | |
| Parent or Guardian Signature (Where Required) | Date |

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# Personal Employment Plan

Name: _____

| | | |
|---|---|---|
| **Dreams and Career Aspirations:** | | **Interests:** |
| **Skills and Knowledge:** | | **Talents:** |
| **Work Experiences:** | | **Positive Personality Traits:** |
| **Environmental Preferences:** | | **Dislikes, Quirks, and Unique characteristics::** |
| **Learning Styles:** | | **Things to Improve and/or Work On:** |
| **Specific Challenges:** | | **Support System and Social Network:** |
| **Possibilities, Ideas, Goals and Next Steps:** | | |



KNOWING YOURSELF IS THE BEGINNING OF ALL WISDOM.
-Aristotle