Kentucky Office of Vocational Rehabilitation

Carl D. Perkins Vocational Training Center (CDPVTC) Application for Admission

Instructions

Purpose:

The purpose of this form is to provide instructions for the application for admission for Carl D. Perkins Vocational Training Center (CDPVTC).

Applicant's Name	Enter the name of the applicant
OVR Counselor	Enter the name of the OVR Counselor
Birth Date	Enter the birth date of the applicant
Age	Enter the age of the applicant
Address	Enter the address of the applicant
Phone Number(s)	Enter the phone number or phone numbers of the applicant

Consumer Release of Information

My program may be discussed with	Enter the name(s) of the person/people that the applicant's program may be discussed with

Transportation

Will you or your family be providing your transportation to the Center?	Select Yes or No on whether the family will be providing transportation to the center.

Pass/Supervision Statement

Check one of the following if the consumer is under 18 or has a court-appointed guardian	Select whether the center is approved to decide on unsupervised trips or if passes can only be issued for the applicant to return home

Medical Information

Do you need assistance with: **walking, eating, bathing, dressing, getting in and out of bed, turning in bed from side to side, toilet transfer or toilet hygiene?**	Select yes or no for each item
Do you use a wheelchair?	Select yes or no
Do you need assistance with propelling your chair?	Select yes or no
Will you bring your wheelchair to the center?	Select yes or no

Medical Information Continued

Do you have pressure sores? (Explain size and location in the space requesting an explanation to any yes answer below the questions)	Select yes or no
Do you have any problems with bowel and bladder control?	Select yes or no
Do you require a special diet?	Select yes or no
Have you traveled outside the United States in the last year?	Select yes or no
Do you take any medication?	Select yes or no
What type and prescribed by	Enter the names of the medication the applicant takes and what doctor(s) prescribed them?
Please explain any yes answer	Explain any yes answer to any of the questions

Policy on use of tobacco products

I currently smoke and/or use other tobacco products (including e-cigarettes)	Select yes or no
I request the staff of the Center include me in activities that can help me quit using tobacco products	Select yes or no

Required Signatures

Signature/Date of applicant or consumer	Request that the consumer or applicant sign and date the form
Approved by (parent or legal guardian)	If the applicant or consumer is under 18 or has a legal guardian, please have that individual sign the form underneath the applicant or consumer's signature
Witness Signature	Have someone sign the form as a witness of the first two signatures, specifically the counselor or the person responsible for the referral