AUXILIARY AIDS
FOR EFFECTIVE COMMUNICATION

Name: ______________________________ Date: ____________________

Address: ______________________________ VR Counselor: _______________

____________________________________

Phone: ______________________________ E-mail: ______________________

Type of Aid(s) preferred:
☐ ASL Interpreter ☐ Materials in large print
☐ Certified Deaf Interpreter ☐ Braille format
☐ Personal listening device ☐ Materials in audio format
☐ C.A.R.T. ☐ Note taker
☐ Materials in written format ☐ Qualified reader
☐ Braille teletouch

☐ Other type of aid (specify): ______________________________

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Initial here if you prefer to provide your own interpreter or other auxiliary aid. However, Nevada Rehabilitation Division is not able to ensure the quality or provision of effective communication when you choose to use your own aids. You may subsequently request and elect to use auxiliary aids provided by the Division any time during your case.

____________________________________ ______
Signature Date

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Effective Date: 07/01/2018