

Vocational Rehabilitation + You = A Job

Vocational Rehabilitation

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Vocational Rehabilitation

What is vocational rehabilitation (VR)?

Vocational rehabilitation (VR) programs offered by the Division of Vocational Rehabilitation and the Division of Visual Services help Oklahomans with disabilities get jobs in careers of their choice. DVR and DVS are divisions of the Oklahoma Department of Rehabilitation Services (DRS).

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How do you contact us?

For more information about vocational rehabilitation and employment services, contact dbowers@drs.state.ok.us. You may also phone our toll free hotline at (800) 487-4042 (Voice) and follow the directions to have your call routed to the nearest office or call (800) 845-8476 (TTY/TDD) to speak with DRS staff.

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Who is eligible?

You are eligible for vocational rehabilitation (VR) services if you have a physical or mental disability that keeps you from working and you need vocational rehabilitation services to prepare for, find, keep or return to employment.

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What is a consumer?

A consumer is an individual with a disability who is eligible for services provided by the Division of Vocational Rehabilitation or the Division of Visual Services through the Oklahoma Department of Rehabilitation Services. We use the word to emphasize that our clients are involved in making decisions about what services they consume or use.

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What services are available?

The primary vocational rehabilitation (VR) services are counseling and guidance with job placement. Other services compensate for, correct or prevent disability-based barriers to employment:

- Medical and/or psychological assessments are used to determine eligibility and review consumers' background, abilities, disability-related barriers to employment and rehabilitation needs.
- Vocational evaluation, counseling and career planning guidance are provided by counselors to consumers throughout the rehabilitation process.
- Information and referral help individuals get appropriate services from other agencies.
- Employment services, including job search, placement and follow-up services, help consumers find and keep suitable employment in their chosen careers.
- Assistive technology, including telecommunications, sensory and other rehabilitation equipment and devices, enable consumers to function more effectively in the workplace.
- Training includes vocational, post-secondary, on-the-job, personal and vocational adjustment training, job search skills development and job coaching.
- Diagnosis and treatment of physical and mental disabilities may be provided to enhance consumers' employment opportunities when services are not available through health insurance or other benefits.
- Maintenance helps pay for additional costs connected with being evaluated to determine eligibility or receiving certain services under an IPE.
- Transportation is provided in connection with other services needed to reach employment goals.
- Instructional services, such as rehabilitation teaching and orientation and mobility services, assist individuals who are blind.
- Self-employment programs help individuals who want to work for themselves, telecommute using computers or operate their own businesses.
- Personal assistance services are available while individuals are receiving VR services.
- Transition School-to-Work services help high school students with disabilities prepare for and reach employment goals.
- Supported employment assists individuals with severe physical, emotional, mental or multiple disabilities with employment in the

community.

- Post-employment services help consumers get, keep or move ahead in their jobs.
- Specialized programs assist consumers who are blind, deaf, hard of hearing, deaf-blind and individuals with speech impairments, severe disabilities and those who require independent living services.
- Foreign language interpreter services enable individuals who do not speak English to participate in their vocational rehabilitation programs.

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What do services cost?

Some services, such as medical examinations to determine if you are eligible for services, vocational counseling and job placement, are always provided at no charge to you. You may be asked to share the cost of some other services, depending on your income and financial resources.

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How do you apply?

Individuals may apply at DVR/DVS field offices located throughout Oklahoma. To find the nearest office, check the [Office Locator](#) feature on this web site or e-mail dbowers@drs.state.ok.us.

You may also phone our toll free hotline at (800) 487-4042 (Voice) and follow the directions to have your call routed to the nearest office or call (800) 845-8476 (TTY/TDD) for further assistance.

Offices can also be located by checking the government "blue pages" in your local phone book.

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What are the steps in the VR process?

Step 1: Applying for services

Staff will arrange for you to make an application and meet with a vocational rehabilitation specialist so you can provide the information needed for Division of Vocational Rehabilitation or Division of Visual Services to determine if you are eligible for services. You can speed up the application process by bringing current medical,

psychological and/or educational records or other information about your disability with you to the appointment.

Step 2: Evaluating your disability

DVR/DVS must evaluate your disability to find out if you are eligible. You may be asked to help get medical or other records. If additional tests are needed, DVR/DVS will pay for the tests needed to determine your eligibility. The purposes of the evaluation are to gather diagnostic information and explore your background, abilities, disability-related barriers to employment and rehabilitation needs.

Step 3: Determining your eligibility

DVR/DVS has 60 days from the time you apply to determine whether or not you are eligible for services unless you and your counselor agree to an extension. Even when you are not eligible for VR services or when you are placed on a waiting list, DVR/DVS will provide vocational rehabilitation information and referral assistance to help you obtain services from other sources.

Step 4: Planning your services

If you are eligible, your DVR/DVS counselor will provide information about choices you have for developing an Individualized Plan for Employment (IPE). This is a plan of VR services that you will follow to get or keep suitable employment in an appropriate career. You will have the opportunity to choose an appropriate employment goal, the vocational rehabilitation services to be provided under your plan, the businesses or companies that will provide the services and the methods for providing those services.

Step 5: Receiving Vocational Rehabilitation Services

The primary vocational rehabilitation (VR) services are counseling and guidance with job placement. Other services compensate for, correct or prevent disability-based barriers to employment:

Step 6: Getting a job

Your counselor will assist you in finding a job. We also have job placement specialists who work with counselors and potential employers to match qualified consumers with suitable employment. Generally, your VR case will be closed after you have worked successfully for 90 days.

Step 7: Using post-employment services

You may be eligible for post-employment services to help keep your job, get your job back, move ahead on your job or move to a better job. If you need a lot of assistance, you may be asked to reapply for services.

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What are your rights?

We are committed to treating individuals with disabilities fairly and with respect. As an applicant and as a consumer, if you are eligible for services, you can expect the Division of Vocational Rehabilitation (DVR) or Division of Visual Services (DVS) to do these things:

- Contact you by phone or in person within 30 days if you are referred for services or ask DVR or DVS about services.
- Evaluate you for and provide DVR/DVS services, if you are eligible, without regard to your race, color, national origin, sex, religion, age, or disability.
- Determine whether you are eligible to receive services, generally within 60 days. If you are legally blind, you will also be referred to a rehabilitation teacher to find out if you are eligible for rehabilitation teaching services.
- Include you as a full participant in decisions about your vocational rehabilitation.
- Look for services and benefits available to you through other programs.
- Provide relevant information so that you can make informed choices about your program.
- Authorize services for you according to your Individualized Plan for Employment (IPE).
- Notify you in writing as soon as possible about any negative decision concerning your case.
- Inform you about your rights and responsibilities as an applicant and/or consumer of DVR/DVS services, including your rights to pursue mediation, get decisions reviewed by an impartial hearing officer and/or get help from the Client Assistance Program (CAP).

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What are your responsibilities?

You also have responsibilities as an applicant or consumer. To help make your vocational rehabilitation a success, you should:

- Provide information and be available to complete the assessment process to find out if you are eligible for services.

- Be on time and keep appointments with Division of Vocational Rehabilitation or Division of Visual Services staff, doctors and others.
- Call in advance or as soon as possible, if you cannot come to an appointment.
- Follow the advice of doctors and other medical professionals.
- Apply for and use benefits, services and additional sources of funding (such as education grants, public welfare programs and private insurance) to help pay for your vocational rehabilitation services if other funding is available to you.
- Participate with your DVR/DVS counselor in developing your Individualized Plan for Employment (IPE).
- Make progress toward completing the steps outlined in your Individualized Plan for Employment (IPE) in order to reach your employment goal.
- Attend education or training classes on a regular basis and make at least passing grades, if your IPE includes these services.
- Review your IPE with your counselor at least once per year and participate in making revisions to the plan when needed.
- Work with your counselor to get or keep suitable employment when your other services are completed.

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What is the Client Assistance Program?

Client Assistance Program (CAP) is an advocacy program which is not part of the Department of Rehabilitation Services (DRS). CAP staff can help you communicate concerns and work out disagreements through administrative, mediation, legal and other solutions. For more information, contact:

Client Assistance Program (CAP)
2712 Villa Prom
Oklahoma City, OK 73107-2423
Phone: (405) 521-3756 Voice/TTY/TDD
Toll Free: (800) 522-8224Voice/TTY/TDD

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NOTE:

WHEN APPLYING FOR VOCATIONAL REHABILITATION SERVICES YOU WILL NEED TO DO THE FOLLOWING TO EXPEDITE THE APPLICATION PROCESS:

- **Complete the application as thoroughly as possible.**
- **Provide recent medical documentation supporting your disability.**
- **Include specific medical information showing how your disability limits your ability to work.**
- **Provide any school records including high school and/or college transcripts as they apply to you.**
- **Return the application to: Vocational Rehabilitation Services #44
217 West 5th Street, P. O. Box 1053, Stillwater, OK 74076.**
- **If you have questions or need assistance in completing the application, please free to contact us at 1-405-372-1995. You may also call our toll free number 1-800-487-4042 (be prepared to enter your zip code when it requests it in order to route your call to the appropriate office).**

**OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
FINANCIAL STATUS DETERMINATION**

Name _____ SSN _____ Phone _____

Address _____

I. ASSETS

A. Total number in family: _____

B. Are you or a family member working full-time or part-time and earning money?

Yes No If yes, complete the following information:

Employed Person	Place of Employment	Monthly Take Home Pay
-----------------	---------------------	-----------------------

C. Do you or any household member have income other than earned income?

Yes No If yes, complete the following:

	Monthly Amount		Monthly Amount
Social Security	_____	Supplemental Security Income	_____
Veterans Benefit	_____	Unemployment Benefits	_____
Retirement Pension	_____	Child Support/Alimony	_____
Rental Income	_____	Business Income/Farm Income	_____
Worker's Compensation	_____	Mineral/Lease Income	_____
Property	_____	Public Assistance Payments	_____
		Other Income	_____

D. Other available resources. (Give total amount in account—not interest earnings)

1. Savings account _____
2. CD's _____
3. Checking account _____

E. Do you or any family member own a car, pickup truck and/or other vehicle?

Yes No If yes, number of vehicles _____

II. MEDICAL DEBTS

Do you or any household member have any medical expenses? Yes No

If yes, complete the following:

	Monthly Amount Paid
Hospital	_____
Medication Payment	_____
Medical Insurance Payment	_____
Disability Related Expenses	_____
Physicians	_____

III. OTHER DEBTS

A. Other family members attending post-secondary school:

Family Member	School	Tuition, Fees, Books
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B. Other Debts (court ordered commitments/child support, etc.)

Type of Debt	Monthly Amount
--------------	----------------

I certify that the information I have given is true, correct and complete to the best of my knowledge. I agree to notify my Vocational Rehabilitation Counselor within 20 days if I have a change in my living arrangement, address, income, bank accounts, automobiles, other resources of any kind, property, expenses or needs.

I understand that the information I have given will be carefully studied and that I might be asked to provide proof of the answers given. I further understand that any false statement makes me subject to prosecution for fraud. I hereby authorize the Department of Rehabilitation Services to make any necessary investigation to verify the information I have given.

When this form is returned, the Vocational Rehabilitation Counselor will review the information and discuss the services Vocational Rehabilitation or Visual Services Division can provide and determine the amount of any financial participation.

Client/Parent/Guardian/Representative Signature

Date

FOR OFFICIAL USE ONLY

FINANCIAL STATUS DETERMINATION

Total Assets (Part I): _____ Total Liabilities (Parts II & III): _____

In-Kind Resources for Zero Income: _____ Basic Living Requirements: _____

Client participation required?: Yes No

If "yes", amount of client participation required: \$ _____

OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
AUTHORIZATION TO DISCLOSE INFORMATION

I, _____ SS# _____ DOB: _____
(client's name)

voluntarily request and authorize _____
(doctor, psychologist, hospital, clinic, agency or school)

to disclose my medical records to:

Name: Dept of Rehabilitation Services
ATTN: Vocational Rehabilitation Specialist #422
Address: P O Box 1053
City, State, Zip Code: Stillwater, OK 74076

The specific type of information to be disclosed is (check one or more as applicable):

- All medical records regarding my treatment, hospitalization, and/or outpatient care
- All psychological or psychiatric records
- All vocational records
- Other, as specified Diagnosis, Prognosis, Most Recent Treatment, pertinent info

The purpose and need for the disclosure is to:

- Establish the individual's eligibility for the vocational rehabilitation program for individuals with disabilities that constitute a substantial impediment to employment
- Assess the vocational rehabilitation needs of the individual for purposes of developing a vocational rehabilitation plan for the individual
- Determine the need for and/or type of treatment for the individual as part of the individual's vocational rehabilitation plan
- Other (specify) _____

The information I authorize for release may include records which may indicate the presence of a communicable or non-communicable disease. I understand that these records may include psychiatric, alcohol and drug abuse information, occupation information, or information regarding other insurance coverage. I specifically authorize the release of my drug, alcohol and/or mental health treatment records.

I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected under the HIPAA Privacy Rule. The Department of Rehabilitation Services is required by federal and state law to maintain the confidentiality of the information with some exceptions. 34 CFR § 361.38 and OAC 612:10-1-5.

RIGHT TO REVOKE: I may revoke this authorization by sending a written request to the Department of Rehabilitation Services, 3535 NW 58th, Suite 500, Oklahoma City, OK 73112.

TERMINATION DATE: This authorization expires twelve (12) months following the date signed by me.

Signature: _____ Date: _____

If not signed by Client, specify basis for authority to sign on Client's behalf:

- Parent
- Representative
- Guardian

VOTER REGISTRATION STATEMENT

Name: _____ Date: _____

IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW,
WOULD YOU LIKE TO APPLY TO REGISTER TO VOTE HERE TODAY?

YES

NO

Signature: _____

1. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.
2. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.
3. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Oklahoma State Election Board, Room 3, P.O. Box 53156, State Capitol, Oklahoma City, Oklahoma 73152, or call 405-521-2391.
4. If you decline to register to vote, the fact that you have declined to register will remain confidential and will be used only for voter registration purposes.
5. If you do wish to register to vote, the office at which you submit a voter registration application will remain confidential and will be used only for voter registration purposes.
6. If you do not check either box, you will be considered to have decided not to register to vote at this time.

OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
VOCATIONAL REHABILITATION AND VISUAL SERVICES APPLICATION

Name _____ SSN _____

What is your disability? _____

Onset of Disability _____

Describe how your disability impairs your ability to work (or to live independently)?

What services do you need? _____

Have you ever applied for rehabilitation services? yes no
If yes when? _____

Do you have a Ticket to Work? yes no Ticket Number _____

Have you ever been convicted of a felony? yes no

Have you ever defaulted on a student loan? yes no

My completion of this document constitutes an application for Rehabilitation Services. In order to effect my rehabilitation, I authorize the release of confidential information from my case file to agencies or others who have adopted regulations for confidentiality. All information both medical and personal given or made available to the agency shall be held to be confidential. Use of such information will be limited to purposes directly connected with the administration of my rehabilitation program. All mandatory information is collected under the authority of the Rehabilitation Act of 1973 as amended by Rehabilitation Amendments of 1992 and 1998; Title 56, Oklahoma Statute 1971, sections 328 through 330 and Title 51 Oklahoma Statute 1985, Section 24A.1 through 24A.18. Failure to provide this information may prevent the rehabilitation agency from providing services in a timely manner. Otherwise, information will not be disclosed to any individual, agency or organizations without my written consent or that of my parent, guardian or representative as applicable.

I attest under penalty of perjury that I am (check one of the following)

A Citizen or national of the U.S. A Lawful Permanent Resident An Alien authorized to work

Information provided is subject to verification through the Social Security Administration.

Client _____ Date _____

Parent/Guardian/
Representative _____ Date _____

VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES

(56 O.S. § 71)

Statement Under Penalty of Perjury

(12 O.S. § 426)

I _____ (D.O.B.) _____ , hereby state as follows:
(Applicant)

I am a United States Citizen.

I state under penalty of perjury under the laws of Oklahoma that the foregoing is true and correct.

Date

County

[Signature of Applicant]



I _____ (D.O.B.) _____ , hereby state as follows:
(Applicant)

I am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States.

I state under penalty of perjury under the laws of Oklahoma that the foregoing is true and correct.

Date

County

[Signature of Applicant]

OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
CLIENT INFORMATION FORM

SSN _____

Last Name _____ First Name _____ Middle Initial _____

Preferred Name _____ Honorific _____ (Jr., MS, PhD., etc.)

Male Female Birth date: _____

Previous Last Name _____ Previous First Name _____

Home Address _____
(Street, Route, P.O. Box #, etc.)

City: _____ State: _____ Zip: _____

County: _____

Mailing Address if different from above: _____

Primary Phone Number _____ Voice TDD Fax

Second Phone _____ Cell Work Alternate

E-Mail Address: _____

Direction to Home: _____

RACE & ETHNICITY:
*If Hispanic or Latino check more than one.
Ex: Hispanic & American Indian*

<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or other Pacific Islander

Is your primary language: English American Sign Language

Native American language Spanish Vietnamese Other

Do you require an alternate correspondence format:

Audio Tape Braille Large Print _____ Other

Will you require any other accommodations? _____

List three people whom we may contact in an attempt to locate you, should your current contact information become outdated.

1. Last Name: _____ First Name: _____
 Relationship: _____ Address/City _____
 Home phone: _____ Cell or work phone: _____
 E-Mail address: _____
2. Last Name: _____ First Name: _____
 Relationship: _____ Address/City _____
 Home phone: _____ Cell or work phone: _____
 E-Mail address: _____
3. Last Name: _____ First Name: _____
 Relationship: _____ Address/City _____
 Home phone: _____ Cell or work phone: _____
 E-Mail address: _____

Do you live in a private residence? yes no

Other: _____

What is your home county of residence? _____

Marital Status: divorced married (includes common-law)
 never married separated widowed

Who referred you to us? _____

Number of family living in your household: _____

LIST ALL HOUSEHOLD MEMBERS WITH INCOME INFORMATION
(Include Wages, SSI, SSDI, TANF, Worker's Comp., Unemployment, etc.)

Name	Relationship	Source of Income	Monthly Amount
	Self		

DRS-C-1(a), page 3
Please check if you have:

- Medicare Medicaid
 Private Insurance through own employment
 Private Insurance through other means
 Public insurance from other sources
 None

Primary Insurance Carrier _____

Policy Number _____

Medicaid Number _____ Medicare Number _____

Level of Education attained at time of this application: _____

Have you received services under an Individualized Education Program (IEP)? yes no

Are you currently a high school transition program participant? yes no

High School

School Name City & State

Highest Grade Completed Dates Attended

College (Most Recent)

School Name City & State

Area of Study Graduated yes no

Hours Earned Degree Earned Dates Attended

Technical

School Name City & State

Area of Study Program Completed yes no

Degree/Certificate Earned Dates Attended

Other Training

School Name City & State

Program Completed yes no

Area of Study _____

Degree/Certificate Earned _____

Dates Attended _____

List Your Last Three Jobs:

1. _____
(Current Job Title) (Employer name & Address) (Weekly Hours) (Weekly Salary)

(Dates Employed: MM/YY – Present) (Disability-related Problems Affecting job)

2. _____
(Job Title) (Employer name & Address) (Weekly Salary)

(Dates Employed: MM/YY – MM/YY) (Reason for leaving)

3. _____
(Job Title) (Employer name & Address) (Weekly Salary)

(Dates Employed: MM/YY – MM/YY) (Reason for leaving)

4. Other Work Experience: _____

Are you currently receiving services from the following programs?

- American Indian Tribal VR Program Hissom
- Transition – Tech Now

Are you a Veteran? yes no

(If yes, list serial number and dates of service _____)

Do you have a Military Service Connected Disability? yes no

Migratory or Seasonal Farm Worker Program? yes no

Projects with Industry? yes no

OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
GENERAL HEALTH CHECKLIST

Full Name _____ Social Security Number _____

Date of Birth _____ Height _____ Weight _____

**IF YES, HAS IT
KEPT YOU FROM
WORKING?**

Please answer "Yes" or "No" to all items.

Do you have. . . .

- | | YES | NO | YES | NO |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. A disorder of eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Frequent dizziness, fainting, or headache; seizures, convulsions, paralysis, or stroke? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. A mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of your lungs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, or other disorder of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Intestinal bleeding, ulcer, hernia, colitis, other disorder of the stomach, intestines, liver, or gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Disorder of kidney, bladder, prostate or reproductive system? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Diabetes, thyroid, or other endocrine disorders? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Arthritis or other disorder of the muscles or bones, including the spine, back or joints? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Absence or amputation of any body part? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Loss of use of arms and legs or other body part? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. A tumor, cancer, or disorder of skin or lymph glands? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Allergies? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Anemia or other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Excessive use of alcohol or any habit-forming drugs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Any other physical or mental condition? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, specify: _____
