

MASSACHUSETTS COMMISSION FOR THE DEAF AND HARD OF HEARING

Interpreter/CART Request Fax Form

(Items marked with (▶) REQUIRED for form to be complete)

Incomplete forms cannot be processed

Please fax to (617) 740-1880

▶ Please check the appropriate box(es) below for Communication Services you need:		
<input type="checkbox"/> INTERPRETER(s)	<input type="checkbox"/> CART PROVIDER(s) ON-SITE <input type="checkbox"/> REMOTE CART	<input type="checkbox"/> BOTH
▶ Today Date:	▶ Your Name:	
▶ Your Phone Number: Ext.	▶ Your Fax Number:	
▶ Your Agency:	Email Address:	
▶ Date of Assignment:		
▶ Beginning Time of Assignment:	▶ End Time of Assignment:	Length of Assignment:
▶ Location/Address of Assignment: (include bldg, floor, room #, et al)		
▶ On-Site Person:	▶ On-Site Phone Number: Ext.	On-Site Email Address:
▶ Description of Situation/Nature of Assignment:		
▶ Name of Deaf or Hard of Hearing Person(s):		
Requested Interpreter/CART Providers:		
For CART Provider Request: Equipment: Please check # of users below: 1-2 users – laptop: ____ 2-3 users – monitor: ____ 3+ users – screen: ____		Please check if equipment loan is needed: ____ Combo Projector: ____ LCD Plate: ____ Screen: ____

Billing Information – (Request will NOT be processed without billing information)

▶ Contact Person:	▶ Phone Number Ext.
▶ Agency Name:	Email Address:
▶ Street Address:	
▶ City, State. Zip	

I adhere to pay the interpreter/CART Provider and will cancel at least 2 business days (Interpreter), 3 business days (CART Provider) without paying fees

Signature: _____

Date: _____

Print Name: _____

Title: _____

FOR OFFICE USE ONLY

Area:	Job #:
Received by:	Entered by: