State of Connecticut
Department of Rehabilitation Services
Interpreting Unit

SERVICE REQUEST

Title of requesting entity: ____
(Business, Company, Agency, Practice name)

Name of individual submitting this request: ________________________________

Phone number of individual submitting this request: ___________________________
(Confirmations are only provided by email)

E-mail address to send confirmation to: ____________________________________

Name of Deaf or Hard of Hearing Participant(s): ______________________________
____

Situation*: (i.e., investigation, trial, interview, surgery, routine appointment, meeting)*
____

Logistical Information:

Date(s)_________________________ Start Time_______am/pm End Time_______ am/pm
Assignment Location: ____________________________________Bldg/Suite:______________
Address: ____Floor and Room# _________
City/State/Zip: ____
On-site Contact: ____________________________ Active Phone Number: ________________

Specific Assignment Information: *Please only fill in below section if applicable*

JUDICIAL: *GA#* _______________________ *Docket #:* ______________________________
Charges: ____
DCF: *Link #*_________________ *Child ID#*_______________ *Child Name*_____________
DOL: *Cost Center #*_______________
Medical: *Department* _________________________ *Doctor Name:* _____________________
Nature of medical appointment: ____

Other additional information (i.e., parking, specific directions): ____________________________
____

Specific interpreter preferred (i.e., gender, CDI, legal): ________________________________

Please complete and return by e-mail, mail or fax.
Phone: 860-697-3570 Fax: 860-730-8413 E-mail: DORS.Interpreting@ct.gov
Mailing address: 183 Windsor Avenue, Windsor, CT 06095

For Office Use Only:

Received:

Assignment #: