

AUTHORIZED REPRESENTATIVE

DR 108 (Rev. 05/08)

 Authorized Representative's Name (Please print or type)

 Address

 City

 State

 Zip Code

I have requested the above-named authorized representative to act on my behalf in my appeal regarding my application for and/or receipt of Rehabilitation Services.

I hereby authorize the Department of Rehabilitation to release any or all information pertaining thereto to the above-named authorized representative.

 Name (Please print or type)

 SSA# (last 4 digits)

 XXX - XX -

 Address

 City

 State

 Zip Code

 Signature

 Date Signed



Mail to:

Rehabilitation Appeals Board
 c/o Department of Rehabilitation
 P. O. Box 944222
 Sacramento, CA 94244-2220