AUXILIARY AIDS
FOR EFFECTIVE COMMUNICATION

Name: ___________________________________ Date: _________________________

Address: ___________________________________ VR Counselor: _________________
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Phone: ___________________________________
E-mail: ___________________________________

Type of Aid(s) preferred:

- ☐ ASL Interpreter
- ☐ Certified Deaf Interpreter
- ☐ Personal listening device
- ☐ C.A.R.T.
- ☐ Materials in written format
- ☐ Materials in large print
- ☐ Braille format
- ☐ Materials in audio format
- ☐ Note taker
- ☐ 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