



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 #: