DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
SIGN LANGUAGE INTERPRETER SERVICES

EMPLOYEE CONTACT FORM FOR GROUP AGENCY

Provider Name: _____ **Federal tax ID number: _____**

ADD OR DELETE EMPLOYEE	NAME	EMAIL	PHONE	CREDENTIALS	VR USE BACKGROUND SCREENING

AUTHORIZED AGENT NAME:	**DVR USE ONLY:**
EMAIL ADDRESS:	**APPROVED BY: _____**
DATE:	**DATE:_____**

MUST SUBMIT COPY OF CREDENTIALS
SUBMIT TO VR VENDOR REGISTRATION VIA
FAX: 850-245-3394
OR
EMAIL: vrvendors@vr.fldoe.org

*ADD MORE PAGES AS NEEDED