Rhode Island Commission on the Deaf and Hard of Hearing
Sign Language Interpreter or CART Request Form

Please complete one request form for each assignment. Incomplete form will not be processed.
Completed form can be sent by fax: 401-222-5736 or email: cdhh.interpreter@cdhh.ri.gov.

Job ID (Office Use Only)

Requester Contact

Name:		**Today Date:**
Company/Business:	**Doctor's Name:**	
Street Address:		
City:	**State:**	**Zip:**
Phone: Home ☐ Work ☐ Cell/Text ☐		**Fax:**
Email:		

On-Site Contact

Name:	**Same Contact as above** ☐
Company/Business:	
Phone: Home ☐ Work ☐ Cell/Text ☐	**Fax:**
Email:	

Assignment/Consumer Information

Date of Assignment:	**One time basis** ☐ **Ongoing basis** ☐ (weekly, monthly, etc)	
Start and End Time of Assignment:	**If known:** Deaf ☐ Deafblind ☐ Hard of Hearing ☐	
Name of Consumer or Patient:		**DOB:**
Consumer's role: Patient/Client ☐ Presenter ☐ Parent(s) ☐ Student ☐ Facilitator ☐ Employee ☐ Service Provider ☐ Participant ☐ *For other, please be specific:*		
Has Consumer Requested for a Specific Interpreter(s)? Yes ☐ No ☐ Male ☐ Female ☐	**Name of Specific Interpreter(s):**	
Communication Preference, if known (ASL, Signed English, tactile, CDI, etc)**:**		
Location/Address of Assignment:		
Building:	**Room:**	**Floor:**
City:	**State:**	**Zip:**
How many Interpreters and/or CART Providers are Needed: **Interpreter(s) =** **CART =**		**CART Projector and Screen Needed:** Yes ☐ No ☐
Description of Situation or Nature of Assignment: Emergency ☐ Group Meeting ☐ One-on-One Meeting ☐ Educational ☐ Legal ☐ Police ☐ Court ☐ Employment ☐ Event ☐ Training ☐ Counseling ☐ Surgery ☐ Medical ☐ Mental Health ☐ Presentation ☐ PLEASE EXPLAIN: _____ *For other, please be specific:*		

Billing Information

Name		**Same Contact as above** ☐
Company/Business		
Street Address		
City	**State**	**Zip**
Phone Home ☐ Work ☐ Cell/Text ☐		**Fax**
Email		

Please note: request will NOT be processed without completed information.

OFFICE USE ONLY

Received By:	Date of Confirmation:
☐ Follow-up (72-96 hours notice) ☐ Filled within less than 72 hours ☐ Filled within more than 72 hours ☐ Canceled: B ☐ C ☐ A ☐ _____	Interpreter and/or CART Provider Name(s) Confirmed:

DATABASE ☐ DETAILS FOR INTERPRETER/CART ☐ REQUESTER ☐

Revised January 2016