DCS DEAF COMMUNITY SERVICES OF SAN DIEGO, INC.

Phone: 619 / 398-2488
Fax: 619 / 398-2490
Videophone: 619 / 550-3464
scheduler@dcsofsd.org
DEAFCOMMUNITYSERVICES.ORG

(DCS Only)
Job #: _____
Interpreter(s) Assigned:
_____
_____

SIGN LANGUAGE INTERPRETER REQUEST FORM

Service Date: _____ Start Time: _____am/pm

Day of the Week: _____ Medical Check-In Time: _____am/pm

End Time: _____am/pm

Name of Deaf Person(s): _____

Nature of Appointment: _____

Medical Record #: _____

Case/Code #: _____

☐ Check here if requesting service for a COUNTY funded program.

Please Indicate # of Participants:		
	Deaf/ Hard-of-Hearing:	Hearing:
Adults:		
Minors (17 & Under):		

Appointment Location: _____

_____

_____

(Please include: Business Name, Full Address, Bldg #, Room #, etc...)

Site Contact Information:

Name: _____ E-mail: _____

Phone: _____ Fax: _____

Requestor Information: ☐ Same As Site Contact

Name: _____ E-mail: _____

Phone: _____ Fax: _____

Number of Interpreters Needed: _____ Preferred Interpreter(s): _____ Male / Female

Additional Information: _____

_____

_____

Mail Invoices to the Address Below:

Company Name: _____ Attn: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ E-mail: _____

PO #: _____ (If Applicable)

Preferred Method of Billing: ☐ Mail ☐ E-mail ☐ Fax