MASSACHUSETTS COMMISSION FOR THE DEAF AND HARD OF HEARING

Interpreter/CART Request Fax Form

(Items marked with (▶) REQUIRED for form to be complete)

Incomplete forms cannot be processed

Please fax to (617) 740-1880

▶ ***Please check the appropriate box(es) below for Communication Services you need:***		
☐ **INTERPRETER(s)**	☐ **CART PROVIDER(s) ON-SITE** ☐ **REMOTE CART**	☐ **BOTH**
▶ Today Date:	▶ Your Name:	
▶ Your Phone Number: Ext.	▶ Your Fax Number:	
▶ Your Agency:	Email Address:	
▶ Date of Assignment:		
▶ Beginning Time of Assignment:	▶ End Time of Assignment:	Length of Assignment:
▶ Location/Address of Assignment: (include bldg, floor, room #, et al		
▶ On-Site Person:	▶ On-Site Phone Number: Ext.	On-Site Email Address:
▶ Description of Situation/Nature of Assignment:		
▶ Name of Deaf or Hard of Hearing Person(s):		
Requested Interpreter/CART Providers:		
For CART Provider Request: Equipment: Please check # of users below: 1-2 users – laptop: ___ 2-3 users – monitor:___ 3+ users – screen: ___	Please check if equipment loan is needed: ___ Combo Projector: ___ LCD Plate: ___ Screen: ___	

Billing Information – (Request will NOT be processed without billing information)

▶Contact Person:	▶Phone Number Ext.
▶Agency Name:	Email Address:
▶Street Address:	
▶City, State. Zip	

I adhere to pay the interpreter/CART Provider and will cancel at least 2 business days (Interpreter), 3 business days (CART Provider) without paying fees

Signature: ***Date:***

Print Name: ***Title:***

FOR OFFICE USE ONLY

Area:	Job #:
Received by:	Entered by: