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CARRIER'S REPORT ON REHABILITATION

TO CHAIR, WORKERS' COMPENSATION BOARD

This report shall be submitted within 30 days after the earliest of the following dates:

a. Date on which lost time (intermittent or continuous) exceeds 12 weeks;

or b. Date on which rehabilitation services were instituted or arranged.

WCB CASE NUMBER	CARRIER CASE NUMBER	CARRIER I.D. NUMBER	DATE OF ACCIDENT
CLAIMANT'S SOC. SEC. NO.	CLAIMANT'S TELEPHONE NO.	CLAIMANT'S DATE OF BIRTH	DATE LOST TIME BEGAN

	NAME	ADDRESS
CLAIMANT		
EMPLOYER		
INSURANCE CARRIER		
ATTORNEY/ REPRESENTATIVE		

1. Claimant's occupation ..... Length of employment .....

2. Claimant's salary .....Type of worker: ❑ Full time ❑ Part time Present compensation rate .....

3. Is claimant's job still available? ❑ Yes ❑ No 4. Degree of disability: ❑ Total ❑ Partial

5. Present condition (include diagnosis, complaints and pre-existing impairments, if any) .....

.....

6. Name, rating and address of attending doctor .....

..... Specialty .....

7. **REHABILITATION**

a. Has medical rehabilitation program, under the supervision of a qualified specialist, been authorized and instituted? ❑ Yes ❑ No

b. Has vocational rehabilitation program been arranged or instituted? ❑ Yes Date instituted ..... ❑ No

c. If Yes to a and/or b, give name, rating and address of specialist and/or name and address of vocational service .....

d. Is a vocational rehabilitation program recommended? ❑ Yes ❑ No

e. If answer is No to a or b, and Yes to d, please explain:

❑ Claimant refused ❑ Doctor refused ❑ Attorney refused ❑ Medically unstable

❑ Other (explain) .....

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Signature _____ Date _____

Title _____ Telephone No. _____