WORKERS' COMPENSATION COMMISSION
PROPOSED VOCATIONAL REHABILITATION PLAN

INSTRUCTIONS: Pursuant to COMAR 14.09.07.11B (3) , a vocational rehabilitation practitioner shall complete this form as soon as practicable after being notified of their selection under COMAR 14.09.07.09 and serve it on all the parties in the case.

CLAIM INFORMATION

WCC Claim #	Date of Injury	DOB	Insurance Company Name	Insurer File #
TT Benefits	SSI/SSDI Benefits	Other Benefits	Insurer's Attorney	Phone number
Claimant's Name:		Phone number	Insurer Rep/Adjuster	Phone Number
Address:			Employer Name/Location	
City	State	Zip Code	VR Counselor's Name	WCC Reg#
Claimant's Attorney	Phone number		VR Counselor's Business Address	
Educational level attained	Pre-injury Wage		Company/DORS Information	Work Phone Number
Pre-injury occupation	Anticipated Wages		Optional: VR counselor's email address	

SECTION I – VOCATIONAL REHABILITATION PLAN INFORMATION

Type of Plan Submission

**Please note that only Section I of the plan is required when extending the duration of VR services

☐ Informational

☐ Passed stated completion date

☐ Plan not signed by: _____

☐ All parties did not agree to the plan (briefly comment)

☐ Extension of Services (An order will not be issued/for filing only)

Date of original Plan submitted to the Commission: _____

Length of the proposed extension: _____

Comments:

SECTION II – PLAN SPECIFICATIONS

Services Proposed Confirm services recommended: (if Self-Employment then skip to D)	JOB PLACEMENT ☐	OJT ☐	RETRAINING ☐	SELF-EMPLOYMENT ☐

A. Duration of Plan: From:_____ To:_____ Plan Cost:_____

B. List Targeted Jobs:

1. _____ DOT #:_____

2. _____ DOT #:_____

3. _____ DOT #:_____

4. _____ DOT #:_____

5. _____ DOT #:_____

C. Service Proposed: (continued)

1) OJT/Training Facility Name:_____

OJT/Training Facility Street Address:_____

OJT/Training Facility City:_____ State:_____ Zip Code:_____

OJT/Training Facility Contact Person:_____

Phone #: _____

D. 1. Claimant's Diagnosis:

a) MMI: ◯ Yes ◯ No Date:_____

b) Released to Return to Work: ◯ Yes ◯ No

c) Give dates and summarize Physical Limitations/Functional Capacity Evaluation:

_____ _____

_____ _____

_____ _____

2. Treating Physician's Concurrence: ◯ Yes ◯ No (Less than six months/unless otherwise explain)
Explanation:

E. Confirm that the Hierarchy of Services has been explored (check the appropriate box)

☐ Return to work same job/same employer ☐ Return to modified job/same employer

☐ Return to work new job/same employer ☐ Return to work new job/different employer

☐ OJT Training ☐ Formal Retraining ☐ Self-Employment

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Section III: Vocational Assessment/Rationale/Supporting Documentation

F. Vocational Assessment: How does the service proposed meet the definition of suitable gainful employment by addressing the qualifications, academics, interests, incentives, pre-disability earning, future earnings, physical appropriateness and labor market conditions?

G. Confirm that supporting documentation is attached:

- ☐ Vocational Assessment(must be included)
- ☐ Vocational test results
- ☐ Physical Limitations/FCE
- ☐ Wage Earnings Research/Analysis
- ☐ Local/Current Labor Market Analysis
- ☐ Plan Cost Outline/Estimates
- ☐ Medical Release to RTW

Section IV: Goals/Responsibilities

BRIEFLY STATE GOALS AND OBJECTIVES:

CLAIMANT'S RESPONSIBILITIES:

VR COUNSELOR'S RESPONSIBILITIES:

EMPLOYER/INSURER'S RESPONSIBILITIES:

C E R T I F I C A T I O N

I,_____, the undersigned disabled covered employee, do hereby certify that I have read the attached Vocational Rehabilitation Plan and that I understand the following:

1. This plan is an agreement that outlines each party's responsibilities with regard to my vocational rehabilitation.

2. The Insurer will pay rehabilitation benefits equal to weekly temporary total disability benefits as well as the expenses of the rehabilitation services.

3. The time frame(s) agreed to by the parties may be extended if necessary. If the Insurer refuses to agree to an extension and I believe I am entitled to additional rehabilitation services, I have the right to request a hearing before the Commission and to have a Commissioner determine whether services should be continued.

4. I am not required to accept any employment offered to me unless I agree that it is suitable employment. I am aware that if the Insurer believes the employment is suitable and I have declined to accept it, the Insurer may discontinue payment of rehabilitation benefits and expenses and assert my non-cooperation. I understand that I may request a hearing to have a Commissioner determine whether the employment offer was suitable employment.

5. The Insurer may stop benefit/expense payments if the Insurer determines that rehabilitation services are no longer necessary or if they determine that I am not cooperating in the rehabilitation effort.

6. If benefit/expense payments are stopped for any reason with which I do not agree, I have the right to request a hearing and have a Commissioner decide the issue.

7. I have a right to be an active participant in my rehabilitation and have both the right and the responsibility to express my desires and expectations.

8. I have a right to confer with an attorney regarding the terms of the rehabilitation plan.

I HAVE READ THIS CERTIFICATION AND/OR HAVE HAD IT EXPLAINED TO ME, AND I UNDERSTAND ITS PROVISIONS.

Printed Name _____ Signature _____

WCC Claim No:_____ DATE:_____

Approval

Claimant must review and sign the certification (Page 4) prior to signing this Approval. The Certification must not be detached from the plan.

Claimant's acknowledgment: ◯ I have ◯ I have not reviewed and signed the Claimant's Certification.

This plan has been reviewed and approved by the undersigned parties:

Claimant: _____ Date: _____

Print or type full name here: _____

Claimant's Attorney: _____ Date: _____

Print or type full name here: _____

Insurer/Employer Representative: _____ Date: _____

Print or type full name here: _____

Insurer/Employer Attorney (if applicable): _____ Date: _____

Print or type full name here: _____

Rehabilitation Counselor: _____ Date: _____

Print or type full name here: _____

Training Representative: _____ Date: _____

Print or type full name here: _____

DORS Counselor (if applicable): _____ Date: _____

Print or type full name here: _____

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