WORKERS' COMPENSATION COMMISSION

DISAGREEMENT WITH PROPOSED VOCATIONAL REHABILITATION PLAN

INSTRUCTIONS: This form is to be used to notify the Commission of a party's disagreement with a proposed vocational rehabilitation plan. This form must be completed and returned to the Commission no later than 15 days from the date of the letter which transmitted the proposed plan to the parties.

CLAIM NUMBER:

CLAIMANT NAME:

EMPLOYER:

INSURER:

The undersigned

◯ Claimant/Claimant's Attorney ◯ Employer/Insurer's Attorney ◯ SIF/UEF ◯ Other _____

a party to this Workers' Compensation Claim, having reviewed the proposed vocational rehabilitation plan, disagrees with the plan for the following reasons:

BY:

FULL NAME: _____

ADDRESS: _____

SIGNATURE: _____ DATE OF REQUEST: _____

CERTIFICATION OF SERVICE

I hereby certify that on this ___ day of _____, 2 ___, I mailed, postage prepaid, a copy of this Disagreement with Proposed Vocational Rehabilitation Plan to all parties and their attorneys.

Signature Date Telephone

CLICK HERE TO CLEAR THE FORM

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410-864-5100 · Email: info@wcc.state.md.us · Web: http://www.wcc.state.md.us