Bureau of Workers' Compensation

Rehabilitation Agreement

Injured Worker Information		
Injured worker name	Date of referral	Claim number

Vocational Rehabilitation Case Manager (VRCM) Information	
VRCM name	Phone number

Statement of Interest in Rehabilitation Services

As an injured worker, I wish to be considered for vocational rehabilitation services. I understand the determination of feasibility for services may involve medical, psychological, and/or vocational evaluation(s) to establish my rehabilitation readiness. To verify feasibility and to develop an authorized rehabilitation plan, I may need to consult with my physician, employer of record, attorney and/or other professional.

I may be asked to participate in an assessment plan to determine my vocational direction or readiness for return-to-work services. I will cooperate fully with the assigned managed care organization (MCO) in the planning process and participate in the prescribed services. I understand these services may include assessments, specific therapy, treatment, assistive devices and vocational programs to meet the return-to-work goals of my plan. Further, I recognize the responsibility for obtaining or maintaining employment is mine, although I may receive assistance through my rehabilitation team.

If a job search is part of my vocational rehabilitation plan, the Ohio Bureau of Workers' Compensation (BWC) will require me to use the employment resources available through the Ohio Department of Job & Family Services (ODJFS) and OhioMeansJobs.com to assist.

I realize BWC expects my active participation to be 40 hours per week or to the extent that I am released by my physician during my rehabilitation plan. If I deviate from planned activities because of illness, injury, employment, or if I desire to discontinue participation, I will notify my VRCM as soon as possible. I understand BWC can reduce living maintenance payments to which I may be entitled for unexcused absence or for other appropriate reasons.

If I apply for a lump-sum settlement, I will notify my VRCM immediately. I understand that failure to do this may result in my being responsible for additional expenses.

I understand that treatment for a condition not allowed in this claim does not imply acceptance of the condition by BWC or the assigned MCO.

Injured Worker Certification

Warning: Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he/she is not entitled is subject to felony criminal prosecution for fraud.

I understand I may not receive compensation from work while receiving living maintenance compensation unless I am participating in a Gradual Return to Work.

I acknowledge the above named VRCM as the vocational rehabilitation provider of my choice at this time.

By signing below, I certify I have read and understand the statements above and agree with these conditions.

Injured worker signature	Date