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DEPARTMENT OF LABOR  
WORKERS' COMPENSATION  
PO BOX 488  
MONTPELIER, VT 05601-0488  
(802) 828-2286

FORM VR 8 Rev 9/08

State File #: \_\_\_\_\_

## NOTICE OF INTENT TO CHANGE VOCATIONAL REHABILITATION PROVIDER

**NOTE:** An injured worker entitled to vocational rehabilitation services has the right to change counselors.

**If you have been found NOT ENTITLED to vocational rehabilitation this form should not be filed.**

Employee Name \_\_\_\_\_

Address \_\_\_\_\_

City/State \_\_\_\_\_ Telephone #: \_\_\_\_\_

### Vocational Rehabilitation Counselor Choice:

#### First VR Provider

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_

#### New VR Provider

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_

I am changing because: \_\_\_\_\_

This notice should be presented to the employer/insurance carrier **prior** to changing vocational rehabilitation counselors to fulfill the requirements of Vermont law, [21 V.S.A. §641(a)]. Notice is required for ALL subsequent changes of counselor.

\_\_\_\_\_  
Print Employee Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Original needs to be forwarded to the Department of Labor

Copies need to be forwarded to: Claimant and Claimant's Attorney, Insurance Carrier and Insurance Carrier's Attorney, New Counselor, and Previous Counselor