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DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION

DOL FORM 22 (Rev. 6/10)

State File No. _____

Ins. Co. File No. _____

Date of Injury _____

AGREEMENT FOR PERMANENT PARTIAL or PERMANENT TOTAL DISABILITY COMPENSATION

IT IS AGREED, between _____, the employee,
whose address is: _____
and _____, the insurance carrier/employer, that the employee suffered an accident while in the employ of _____
and that the employee sustained the following injury: _____
which resulted in temporary total disability beginning on _____, 20 _____ or [] no lost time.

WEEKLY COMPENSATION RATE

Employee's average weekly wage (AWW) before the accident was \$ _____ S/he is entitled to compensation at the rate of 66 2/3
percent of said AWW or \$ _____ per week. This is updated on July 1 of each year and is now \$ _____ per week.
A transcript of the employee's wages for the twelve/twenty-six weeks was previously submitted or is attached.

Day of the week the check will be mailed to the claimant or deposited in the claimant's account _____

MEDICAL, HOSPITAL AND SURGICAL SERVICES

That the employee shall receive medical services and supplies in accordance with 21 VSA§640.

PERMANENT PARTIAL or PERMANENT TOTAL DISABILITY

Employee is entitled to: Permanent Partial Disability _____ Permanent Total Disability _____

At the end of temporary total or temporary partial, on the _____ day of _____ 20 _____ the employee having either
[] returned to work or [] reached an end medical result for which a discontinuance, Form 27 was filed on _____

The impairment rating is _____. This impairment represents a payment of compensation benefits for a period of _____ weeks.
The impairment rating is based upon the following medical report: Dr. _____

If payment is to be in a lump sum please complete one of the paragraphs below:

Claimant agrees to accept and the employer/carrier agrees to pay a lump sum of \$ _____. This lump sum is compensation for
permanent impairment that will affect the claimant for the rest of his/her life. The claimant's remaining life expectancy is _____ years
or _____ months. Therefore, even though paid in a lump sum, claimant's benefit (after deduction of attorney fees
of _____ and expenses of _____) shall be considered to be _____ /months \$ _____ per month
beginning on the date of approval of this settlement

OR

Claimant agrees to accept and the employer/carrier agrees to pay a lump sum of \$ _____. Claimant expressly requests that
the lump sum not be prorated as otherwise required by 21 V.S.A. §652(c)

The employee is entitled to seek an opinion on permanent impairment from his/her treating physician

APPROVAL AND REVIEW

This agreement is subject to review by the Commissioner and shall not be binding or operative until approved.

Insurance Adjuster Name (Print) _____

Employee Signature _____ Date _____

Insurance Adjuster Signature _____

Official Title _____ Date _____

APPROVED: _____ Date _____

Commissioner of Labor/Designee _____