VERMONT
www.labor.vermont.gov

Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

State File No.: _____
Ins. Co. File No.: _____
Date of Injury: _____

VOCATIONAL REHABILITATION

☐ **ENTITLEMENT** ☐ **PLAN** ☐ **AMENDMENT** ☐ **PROGRESS REPORT**
☐ **CLOSURE** ☐ **SUSPENSION** ☐ **SELF-EMPLOYMENT WORKBOOK**
☐ **EXTENSION**

DATE OF REPORT _____

Employee Name _____
Street _____
City/State/Zip _____
DOB _____ Telephone No. _____
Occupation at time of injury _____ DOT Code _____
Education _____ AWW _____
Treating Physician _____ Type of Injury _____
Represented? ☐ Yes ☐ No If yes, attorney name: _____
Employee's E-Mail Address _____

Employer Name _____
Street _____ Telephone No. _____
City/State/Zip _____ Referral Date _____

Ins. Co. Name _____
Street _____ Telephone No. _____
City/State/Zip _____ Adjuster _____
Represented? ☐ Yes ☐ No If yes, attorney name: _____

V R Counselor _____
V R Company _____
Street Address _____
City/State/Zip _____
Phone _____ Fax _____