Department of Labor
Workers' Compensation
PO Box 488
Montpelier, VT 05601-0488

Rev. 8/13

Vocational Rehabilitation Referral Form

EMPLOYEE INFORMATION

Employee Name: _____ State File Number: _____

Mailing Address: _____

City/State/Zip: _____ Date of Injury: _____

DOB: _____ Telephone No.: _____ AWW: _____

Occupation at time of injury: _____

Claimant's E-mail Address: _____

Claimant's Attorney: _____

Attorney E-mail Address: _____

Treating Physician: _____ Type of Injury: _____

EMPLOYER INFORMATION

Employer: _____ Fed. ID No.: _____

Mailing Address: _____ Telephone No.: _____

City/State/Zip: _____ Contact Person: _____

INSURANCE CARRIER INFORMATION

Insurance Company: _____ Referral Date: _____

Mailing Address: _____ Ins. Co. File #: _____

City/State/Zip: _____ Telephone No.: _____

Carrier's Attorney: _____ Adjuster: _____

Adjuster/Attorney E-mail Address: _____

VOCATIONAL REHABILITATION COUNSELOR INFORMATION

VR Counselor: _____

VR Company: _____

Mailing Address: _____

City/State/Zip: _____

Telephone Number: _____ Fax Number: _____

Counselor's E-mail Address: _____

Notes: _____

_____

Adjuster's Signature: _____