

**NOTIFICATION OF VOCATIONAL SERVICES
by Private Rehabilitation Specialist**

**Department of Workforce Development
Worker's Compensation Division**
201 E. Washington Ave., Rm. C100
P.O. Box 7901
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Return completed copy: One to insurance company (or self-insured employer) and one copy to Worker's Compensation Division.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

EMPLOYEE	WC Claim Number		Employee Name		
	Social Security Number		Employee Address (Number, Street, City, State, Zip Code)		
	Injury Date		Date of Birth	Telephone Number ()	
	Employer Name				
	Diagnosed Disability/Injury				
	Employee's Work Restrictions/Limitations				
INSURER	Insurance Company				
	Mailing Address (Number, Street, City, State, Zip Code)				
	Claim Representative		Telephone Number ()		
VOCATIONAL REHABILITATION SPECIALIST	Name (Please print)				
	WCD Certification Number		Telephone Number ()		
	Agency Name				
	Mailing Address (Number, Street, City, State, Zip Code)				
Check Services Planned: <input type="checkbox"/> Vocational Evaluation <input type="checkbox"/> Job Placement <input type="checkbox"/> Retraining Plan Development <input type="checkbox"/> Other (Describe): _____					
This is notification that I have been selected by the above-named individual to provide necessary vocational rehabilitation services to help that individual return to work.					
Vocational Rehabilitation Specialist Signature			Date Case Opened		