

PRIVATE VOCATIONAL REHABILITATION SERVICES QUARTERLY REPORT

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
<http://dwd.wisconsin.gov/wc>
e-mail: DWDDWC@dwd.wisconsin.gov

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].

The Quarterly Report should be completed for each WC claimant receiving return to work services from the certified specialist and submitted to the WC Rehabilitation Unit by the 5th day of the months April, July, October and January of each year.

Claimant Name _____ Social Security Number _____
Provider Name _____ Provider Number _____
Provider Address _____

CURRENT STATUS

Please check the appropriate boxes and fill in the blanks as requested.

- Denied private rehabilitation services by the carrier because _____
- Conducting Job Search
- In Retraining for _____ weeks in _____ program
- Employed (check the correct response)
 - 1. Same employer: Same job Different job
 - 2. Different employer
- Post injury wage _____ per week
- Post injury occupation _____
- No longer eligible, case fully compromised
- Claimant terminated relationship because _____
- Specialist terminated relationship because _____

CLOSURE INFORMATION

Please fill in the blanks and check the appropriate box as requested.

_____ Number of days in Job Search before placement
_____ Costs of Job Search phase, and _____ Hourly rate for service
_____ Number of weeks in Retraining
_____ Costs of services during or following retraining

Did your costs exceed the cap as determined per DWD 80.49(7)(e)? Yes No If yes, please describe what arrangements were made among all concerned parties to cover your fees? _____

Signature: _____ Date Signed: _____