



**Instructions**

- Please print or type.
- Make sure to enter four digits for the year in all date fields.
- If you have any questions, please call your case manager.
- **Injured worker**, return completed form to your case manager.
- **Case manager**, please follow the distribution list at the bottom of the form.

| Injured Worker Information |         |               |              |
|----------------------------|---------|---------------|--------------|
| Injured worker name (Last) | (First) | (MI)          | Claim number |
| Social Security number     |         | Referral date |              |

| Statement of Interest in Rehabilitation Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| <p>As an injured worker, I wish to be considered for return-to-work rehabilitation services. I understand the determination of feasibility for services may involve medical, psychological and/or vocational evaluation(s) to establish my rehabilitation readiness. To verify feasibility and to develop an authorized rehabilitation plan, I may need to consult with my physician, employer of record, attorney and/or other professionals.</p> <p>Once rehabilitation services appear feasible, and I become active in an authorized rehabilitation plan, I will cooperate fully with the assigned managed care organization (MCO) in the planning process and participate in the prescribed services. I understand these services may include specific therapy, treatment, assistive devices and vocational programs to meet the return to work goals of my plan. Further, I recognize the responsibility for obtaining employment is mine, although I may receive assistance through my rehabilitation plan.</p> <p>I realize BWC expects my active participation to be 40 hours per week during my rehabilitation plan, whenever possible. If I deviate from planned activities because of illness, injury, employment, or if I desire to discontinue participation, I will notify my vocational rehabilitation case manager as soon as possible. I understand BWC can reduce living maintenance payments to which I may be entitled for unexcused absence or for other appropriate reasons.</p> <p>If I apply for a lump sum settlement, I will notify my vocational rehabilitation case manager immediately. I understand that failure to do this may result in my being responsible for additional expenses.</p> <p>I understand that treatment for a condition not allowed in this claim, does not imply acceptance of the condition by BWC or the assigned MCO.</p> |

| Injured Worker Certification                                                                                                                                                                                                                                                                                                                                                                          |      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
| <p>Warning: Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he/she is not entitled, is subject to felony criminal prosecution for fraud.</p> <p>By signing below, I certify I have read and understand the statements above and agree with these conditions.</p> |      |
| Injured worker signature                                                                                                                                                                                                                                                                                                                                                                              | Date |

**Distribution:** BWC claim file, injured worker, injured worker representative, employer, employer representative