



DIA Board # _____ (Required)

OEVR Form #152 Page 1 of 2

AMENDMENT, SUSPENSION, OR CLOSURE OF VOCATIONAL REHABILITATION

Check One: *AMENDMENT* *SUSPENSION* *CLOSURE*

Employee: _____ DIA Board #: _____

Street Address: _____

City, State, Zip: _____

Adjuster: _____

VR Provider: _____

Address: _____

VR Specialist: _____ Tel. Number: _____

Vocational Goal: _____ DOT Code: _____

Complete the following if you are AMENDING OR SUSPENDING the VR plan:

1. Reason for Amendment.Suspension: _____

2. Proposed Amendment to Plan (attach other sheet if needed): _____

3. Additional VR Services and costs that are required:

SERVICES	FROM	TO	ESTIMATED COST
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Signatures

Employees' signature: _____ Date: _____

VR Specialist: _____ Date: _____

Insurer's Rep: _____ Date: _____

OEVR Rehab Review Officer: _____ Date: _____



DIA Board # _____ (Required)

Complete the following if you are CLOSING the Rehabilitation Plan:

Complete the following if the employee is working;

- Returned to Work with same employer, modified job.
- Returned to Work with same employer, different job.
- Returned to Work with different employer, similar job.
- Returned to Work with different employer, different job.
- Retrained, Returned to Work with same employer.
- Retrained, Returned to Work with different employer

If employer is different from former employer, please complete the following:

Employer Name: _____

Address: _____

Return to Work Date: _____ Hourly Wage \$ _____ AWW \$ _____

Has Employee been continuously employed for 60 days: Yes No

Occupational Title: _____ DOT Code: _____

VR Provider Expenses (voc. Testing, TSA, C&G, etc):

\$ _____

Other VR expenses- tuition, fees, B/S, transportation, etc): \$ _____

Total VR Costs: \$ _____

REASON FOR CLOSURE (check all that apply):

CLOSURE DATE: _____

- | | |
|---|---------------------------|
| 1. Medical condition precludes rehabilitation | 7. Employee is Relocating |
| 2. Not likely to benefit from further rehabilitation | 8. Non- cooperation |
| 3. RTW on own accord prior to finalized IWRP | 9. Other (explain) _____ |
| 4. Retired or deceased | _____ |
| 5. IWRP services completed w/o RTW – Plan expired | _____ |
| 6. IWRP services completed: rehabilitation successful | _____ |

Note: Upon completion of form, please sign on the front!