THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF INDUSTRIAL ACCIDENTS

Office of Education and Vocational Rehabilitation
1 Congress St. Suite 100, Boston Massachusetts 02111
Information Line (617) 727-4900 ext. 7303 in Massachusetts
(800) 323-3249 ext. 7303 Outside Massachusetts
http://www.mass.gov/dia/oevr

DIA Board #_____(Required)

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:_____

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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 Worth 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 (Vocational Testing, TSA, C&G, etc): $_____

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

Total VR Costs: $_____

REASON FOR CLOSURE (please only check one):

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

CLOSURE DATE:_____

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