MARYLAND WORKERS' COMPENSATION COMMISSION

VOCATIONAL REHABILITATION CLOSURE REPORT

Claimant's Name: ________________________________ WCC Claim#: ____________________

Practitioner: ____________________________________ WCC Registration #: ____________________

Date of termination of services: __________________________ Date of Report: ____________________

Have all parties been notified of termination of services within 5 working days? ☐ Yes ☐ No

If "No," please explain why: ____

Rehabilitation services provided: Enter service code(s) ☐ ☐ ☐ ☐

01. Vocational rehabilitation counseling/coordination
02. Vocational evaluation
03. Vocational assessment
04. Medical case management/coordination

Programs provided: Enter service code(s) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

11. Direct job placement
12. On-The-Job Training program
13. Self employment
14. Job-club
15. FCE
16. Work hardening
17. Pain management programs
18. Job modification
19. Other: ____

Reason for termination: Enter appropriate code

21. Returned to work with the same employer, same job
22. Returned to work with the same employer different job
23. Returned to work with a new employer, same occupation
24. Returned to work with a new employer, different occupation
25. Self employment
26. Return to work is not feasible (Explain)
27. Claimant declined rehabilitation services
28. Claimant was not actively participating in the rehabilitation program
29. Claimant moved out of state
30. Claimant declined job offers that were within the scope of the rehabilitation plan
31. Other: ____

If returned to work, complete the following:

Pre-injury AWW: __________

Current AWW: __________

Comments/Explanations: ____

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CERTIFCATION OF SERVICE

I hereby certify that on the _____ day of __________ , 2 ____, I mailed, postage prepaid, a copy of the foregoing Vocational Rehabilitation Services Closure Report and any attached documentation to all parties and their attorneys.

______________________________ ____________________

Signature Date

____

Telephone

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