NOTIFICATION OF VOCATIONAL SERVICES
by Private Rehabilitation Specialist

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

Return completed copy: One to insurance company (or self-insured employer) and one copy to Worker's Compensation Division.

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

EMPLOYEE	WC Claim Number	Employee Name	
	Social Security Number*	Employee Address (Number, Street, City, State, Zip Code)	
	Injury Date	Date of Birth	Telephone Number ( )
	Employer Name		
	Diagnosed Disability/Injury		
	Employee's Work Restrictions/Limitations		
INSURER	Insurance Company		
	Mailing Address (Number, Street, City, State, Zip Code)		
	Claim Representative	Telephone Number ( )	
VOCATIONAL REHABILITATION SPECIALIST	Name (Please print)		
	WCD Certification Number	Telephone Number ( )	
	Agency Name		
	Mailing Address (Number, Street, City, State, Zip Code)		

Check Services Planned: ☐ Vocational Evaluation ☐ Job Placement ☐ Retraining Plan Development ☐ Other (Describe): _____

This is notification that I have been selected by the above-named individual to provide necessary vocational rehabilitation services to help that individual return to work.

Vocational Rehabilitation Specialist Signature	Date Case Opened