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| Department of Labor and Industries  Claims  PO Box 44291  Olympia WA 98504-4291 | **state seal** | **Vocational Recovery Referral Closing Report**  **Further Services** |

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| Date of Report |
|  |
| Worker Name | | Claim Number | |
|  | |  | |
| Assigned VRC Name | VRC Provider Number | VRC Phone Number | |
|  |  |  | |
| VRC Signature | | Date Signed | |
|  | |  | |

The purpose of this report is to communicate the referral outcome in accordance with [RCW 51.32.095](https://app.leg.wa.gov/RCW/default.aspx?cite=51.32.095), [WAC 296-19A-050](https://app.leg.wa.gov/wac/default.aspx?cite=296-19A-050) and [WAC 296-19A-060](https://app.leg.wa.gov/wac/default.aspx?cite=296-19A-060)(2), and the Vocational Recovery Referral guideline located in the [Vocational Recovery Reference Manual](https://lni.wa.gov/claims/_docs/vocationalrecoveryreferencemanual.pdf).

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| --- | --- |
| Date Worker Contacted RE: SAS1 | Date RTW Options Ruled Out |
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**Section 1**

Address the Return-to-Work Options with the Employer of Injury

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| Describe exploration of options with the worker and employer. Include exploration with the worker of alternate work, Stay at Work and Preferred Worker programs, and job modification with the employer. |
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**Section 2**

Address the Return-to-Work Options with New Employer

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| Outline the work you did to enable your client to return to work with a new employer. Include job search readiness activities and alternate work explored. *Refer to the Vocational Recovery guideline located in the* [Vocational Recovery Reference Manual.](https://lni.wa.gov/claims/_docs/vocationalrecoveryreferencemanual.pdf) |
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**Section 3**

Describe the vocational recovery plan for assessment

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| What are the worker’s goals?  What steps or interventions are required for the worker to re-enter the workforce?  Describe the worker’s medical status and any planned treatment. |
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**Preferred Worker Program**

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| --- | --- | --- | --- | --- | --- | --- |
| Did you submit an application to the claim file? |  | Yes |  | No | If yes, date submitted: | \_\_\_\_\_\_\_\_\_\_\_\_ |
| If no, please explain | | | | | | |
|  | | | | | | |

**Job Analysis and Descriptions:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Did you attach all of the medically reviewed JAs and/or JDs? |  | Yes |  | No |  |
| If no, please explain | | | | | |
|  | | | | | |

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| Please list all attachments: |