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

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| --- |
| Date of Report |
|  |
| Worker Name | | | Claim Number | |
|  | | |  | |
| Recommended Outcome Code and Code Narrative | | | | |
|  | | | | |
| 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).

Depending on the outcome, complete only ONE of the categories below:

**(1) For RTW Outcomes**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of RTW | Wage | Date of Medical Release | Date CM Contacted RE: RTW |
|  |  |  |  |

**(2) For ATW Outcomes**

|  |  |  |
| --- | --- | --- |
| Date Worker Contacted RE: ATW | Date ATW or Medical Release | Date CM Contacted RE: ATW |
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**Section 1**

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

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| Identify the return to work job (JOI or alternate work) or 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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| --- | --- |
| Worker Name | Claim Number |
|  |  |

**Section 2**

Address the Return-to-Work Options with a New Employer

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| Outline your work 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) |
|  |

**Section 3**

Describe the Vocational Recovery Plan

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| What were the significant steps or interventions that helped reach the outcome? |
|  |

**Preferred Worker Program**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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: |