

VOCATIONAL ASSESSMENT

K-WC-R 93-3A (11-16)

Vendor: _____ Insurance carrier: _____

Counselor: _____ QRP number: _____

Adjuster: _____ Phone: _____

Claimant: _____ Social Security number: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Date of birth: _____ Date of accident (D/A): _____

Employer at D/A: _____ Weekly earnings at D/A: \$ _____

Appraisal of the claimant's previous education, training, qualifications and work experience, including the essential functions performed in the past five years:

Current medical status including physical and/or mental limitations imposed by the occupational injury or disease:

Does claimant retain the capacity to return to same job, same employer?

YES NO

If NO, will the employer/insurance company offer a plan to attempt to modify the job or accommodate the injured worker?

YES NO

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Other pertinent considerations:

SUMMARY

This section should document and provide rationale for the claimant needing or not needing rehabilitation services. Identify the specific problems or obstacles the claimant will have in returning to work and earning a comparable wage:

Would a vocational rehabilitation plan be appropriate? YES NO

If YES, are the parties willing to have a plan developed? YES NO Unknown

If YES, and plan development is agreed upon, submit a rehabilitation plan R93-3B with the signature of all parties.

Counselor signature: _____ Date: _____

Attach medical and vocational reports to support vocational assessment.

cc: