Ohio | Bureau of Workers' Compensation

Rehabilitation Agreement

Instructions
- Please print or type.
- Make sure to enter four digits for the year in all date fields.
- If you have any questions, please call your case manager.
- **Injured worker,** return completed form to your case manager.
- **Case manager,** please follow the distribution list at the bottom of the form.

Injured Worker Information			
Injured worker name (Last)	(First)	(MI)	Claim number
Social Security number	Referral date		

Statement of Interest in Rehabilitation Services

As an injured worker, I wish to be considered for return-to-work rehabilitation services. I understand the determination of feasibility for services may involve medical, psychological and/or vocational evaluation(s) to establish my rehabilitation readiness. To verify feasibility and to develop an authorized rehabilitation plan, I may need to consult with my physician, employer of record, attorney and/or other professionals.

Once rehabilitation services appear feasible, and I become active in an authorized rehabilitation plan, I will cooperate fully with the assigned managed care organization (MCO) in the planning process and participate in the prescribed services. I understand these services may include specific therapy, treatment, assistive devices and vocational programs to meet the return to work goals of my plan. Further, I recognize the responsibility for obtaining employment is mine, although I may receive assistance through my rehabilitation plan.

I realize BWC expects my active participation to be 40 hours per week during my rehabilitation plan, whenever possible. If I deviate from planned activities because of illness, injury, employment, or if I desire to discontinue participation, I will notify my vocational rehabilitation case manager as soon as possible. I understand BWC can reduce living maintenance payments to which I may be entitled for unexcused absence or for other appropriate reasons.

If I apply for a lump sum settlement, I will notify my vocational rehabilitation case manager immediately. I understand that failure to do this may result in my being responsible for additional expenses.

I understand that treatment for a condition not allowed in this claim, does not imply acceptance of the condition by BWC or the assigned MCO.

Injured Worker Certification

Warning: Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he/she is not entitled, is subject to felony criminal prosecution for fraud.

By signing below, I certify I have read and understand the statements above and agree with these conditions.

Injured worker signature	Date

Distribution: BWC claim file, injured worker, injured worker representative, employer, employer representative