CHECK BOX IF THIS REQUEST ADDS REHABILITATION ISSUES TO A PENDING REHABILITATION REQUEST ☐

Rehabilitation Request

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

NOTE: Before filing this form, call the workers' compensation insurer. If that does not resolve the issue, call Workers' Compensation Benefit Management and Resolution Unit at (651) 284-5032 (or 1-800-342-5354).

RQ03

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	PHONE # (include area code)

EMPLOYEE ADDRESS			INSURER/SELF-INSURER/TPA		
CITY	STATE	ZIP CODE	INSURER ADDRESS		
EMPLOYER NAME			CITY	STATE	ZIP CODE
EMPLOYER ADDRESS			CLAIM REPRESENTATIVE NAME		
CITY	STATE	ZIP CODE	INSURER CLAIM #	INSURER PHONE #	EXT

INSTRUCTIONS:

- This form must be filled out **completely**; otherwise, it may be **returned** to you.
- The injured worker's name, WID or social security number, and date of injury must be written on all attached documents.
- This form may not be used to request wage loss, medical, or permanent partial disability benefits.

I AM INTERESTED IN TRYING TO RESOLVE ISSUES INFORMALLY THROUGH MEDIATION.
For more information, call the Benefit Management and Resolution Unit at (651) 284-5032 or 1-800-342-5354. ☐ **YES** ☐ **NO**

1. **THIS REQUEST IS BEING COMPLETED BY:**

☐ Employee ☐ Employee's Attorney ☐ Employer ☐ Insurer/TPA Self-insured ☐ Insurer's Attorney ☐ QRC/ Vendor

2. **REHABILITATION ISSUES (check only those that apply)**
I request:

☐ a. that rehabilitation services/consultation be provided. Attach medical report which lists restrictions.

☐ b. a change of QRC (qualified rehabilitation consultant):

FROM	
	NAME
	FIRM NAME
	ADDRESS
	PHONE # (include area code)

TO	
	NAME
	FIRM NAME
	ADDRESS
	PHONE # (include area code)

☐ c. that the rehabilitation plan be changed.

☐ d. retraining or exploration of retraining.

☐ e. that the rehabilitation plan be terminated.

☐ f. that the rehabilitation plan be suspended.

☐ g. that the employee's rehabilitation expenses be reimbursed. Attach itemized bills and supporting documentation.

☐ h. that QRC/vendor bills be paid. Attach supporting QRC/vendor reports and itemized bills.

☐ i. other (explain)

3. Explain the details of your request. Attach all documents, such as medical reports and rehabilitation reports/bills, which support your request. A decision may be based solely on these documents, the Workers' Compensation Division file, and the response to this form.

4. Send a copy of this form and all attachments to all parties, including the employee, employer, insurer, QRC/vendor and attorneys. Provide the names and addresses below. Attach extra sheets if necessary.

NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
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NAME	ADDRESS	CITY, STATE, ZIP CODE

I sent a copy of this form and all attachments to the parties listed in #4 on _____ (date)

PRINT NAME OF PERSON FILING THIS REQUEST			SIGNATURE		
ADDRESS			ATTORNEY REGISTRATION #		
CITY	STATE	ZIP CODE	PHONE # (include area code)	EXT	DATE SIGNED

WHEN YOU HAVE FULLY COMPLETED THIS FORM, SEND IT AND ALL ATTACHMENTS TO:

Benefit Management and Resolution Unit
Workers' Compensation Division
Department of Labor and Industry
PO Box 64218
St. Paul, MN 55164-0218

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.