

Rehabilitation Plan And Award

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs



INSTRUCTIONS: Complete items 1 through 13 and send to the Division of Rehabilitation. Attach the maintenance request, complete testing or work evaluation information and the justification for the rehabilitation program. No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing law and regulations. OWCP exercises discretion to terminate or revise the plan when it becomes evident that the planned conditions will not be met. **Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.**

OMB No. 1215-0067
Expires: 07-31-08

1. Name of injured worker (First, middle initial, last)	2. Date of Birth (Mo., Day, yr.)	3. OWCP No.
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4. Address (Number, street, city, state, ZIP Code)

5. Rehabilitation services or program	6. Rehabilitation period (Month, day, year) From _____ to _____
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7. Name and address of rehabilitation facilitator (school, etc.)	8. Is this complete plan? <input type="checkbox"/> Yes <input type="checkbox"/> No - Explain
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9. Occupation after rehabilitation program	10. Estimated yearly earnings after rehabilitation program \$ _____
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11. REHABILITATION COST			
a. Fees - Specify			e. Other costs Specify
_____ \$ _____ per _____ x _____ = \$ _____			_____ \$ _____ per _____ x _____ = \$ _____
_____ \$ _____ per _____ x _____ = _____			_____ \$ _____ per _____ x _____ = _____
_____ \$ _____ per _____ x _____ = _____			_____ \$ _____ per _____ x _____ = _____
_____ \$ _____ per _____ x _____ = _____			_____ \$ _____ per _____ x _____ = _____
Do not include amounts previously authorized on OWCP-35			f. TOTAL OTHER COST = \$ _____
b. TOTAL FEE COST	\$ _____		g. Tuition \$ _____ per _____ x _____ = \$ _____
c. Supplies (Books, tools, etc.)			h. Maintenance \$ _____ per _____ x _____ = \$ _____
_____ \$ _____ per _____ x _____ = \$ _____			
_____ \$ _____ per _____ x _____ = _____			
d. TOTAL SUPPLIES COST	\$ _____		TOTAL REHABILITATION COST \$ _____

12. INJURED WORKER: I understand and approve of the provisions of this plan of services. I believe this plan will help me to get and keep suitable employment and I will cooperate in every way possible to carry out the plan successfully.

Signature _____ Date signed _____

13. COUNSELOR RECOMMENDING PLAN: A thorough vocational evaluation was performed and employment may reasonably be expected as a result of the implementation of the rehabilitation plan considering the interest and abilities of the injured worker, the competence of the rehabilitation facilitator, and the nature of the job market.

Signature _____ Date signed _____

FOR OWCP DISTRICT OFFICE USE ONLY BELOW THIS SPACE

14. Date of injury	15. Date of referral to OWCP Rehabilitation	16. Date of referral to Rehabilitation Agency	17. Date of maximum medical recovery
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18. Was there a previous plan? <input type="checkbox"/> No <input type="checkbox"/> Yes-Mark (X) one <input type="checkbox"/> Successive to previous plan <input type="checkbox"/> Change of previous plan - Enter Date _____	19. Payment -This award is payable from the fund created by the following compensation law. Mark (X) one. <input type="checkbox"/> Federal Employees' Compensation Act <input type="checkbox"/> Longshore and Harbor Workers' Compensation Act <input type="checkbox"/> District of Columbia Compensation Act
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20. RECOMMENDATION OF OWCP REHABILITATION SPECIALIST: The injured worker meets the eligibility requirements for OWCP rehabilitation services. I have reviewed the rehabilitation plan and find it within the interest and ability of the injured worker. The facilitator is competent to provide the services.

Signature _____ Date signed _____

21. APPROVAL OF DISTRICT DIRECTOR: I concur with the OWCP rehabilitation specialist, and hereby award the foregoing benefits for payment (1) for the purpose of providing additional compensation for maintenance and/or (2) for the purpose of providing necessary rehabilitation services in connection with a rehabilitation plan.

Signature _____ Date signed _____

Public Burden Statement

We estimate that it will take an average of 30 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE