Rehabilitation Plan And Award

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U.S. Department of Labor
Office of Workers' Compensation Programs

INSTRUCTIONS: Complete items 1 through 13 and send to the Vocational Rehabilitation Specialist. Attach a justification for the proposed rehabilitation program. Itemize program costs below, not including amounts previously authorized. 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. 1240-0045
Expires: 07-31-2011

1. Name of injured worker (First, middle initial, last)

2. Date of Birth(Month/Day/Year)

3. File No.

4. Address (Number, street, city, state, ZIP Code)

5. Rehabilitation services to be provided

6. Expected Plan Duration (entire date range)
From to

7. Names and address of rehabilitation provider (school, etc.)

8. Is this the complete plan?
☐ Yes ☐ No - Explain

9. Expected occupation(s) after completing rehabilitation program

10. Estimated yearly earnings after rehabilitation program
$

11. REHABILITATION COST

a. Fees - Specify

	$		per		x		=	$					
	$		per		x		=	$					
	$		per		x		=	$					
	$		per		x		=	$					
	$		per		x		=	$					

Do not include amounts previously authorized on OWCP-35.

b. TOTAL FEE COST $

c. Supplies (Books, tools, etc.)

	$		per		x		=	$					
	$		per		x		=	$					

d. TOTAL SUPPLIES COST $

e. Other costs - Specify

	$		per		x		=	$					
	$		per		x		=	$					
	$		per		x		=	$					
	$		per		x		=	$					
	$		per		x		=	$					

f. TOTAL OTHER COST $

g. Tuition $ per x = $

h. Maintenance $ per x = $

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. I understand that my failure to cooperate may result in a suspension of benefits and that my compensation may be reduced at the completion of this program regardless of my success in obtaining employment (FECA only).

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 provider, and the nature of the job market.

Signature Date signed

FOR OWCP DISTRICT OFFICE USE ONLY BELOW THIS SPACE

14. Was there a previous plan?
☐ No
☐ Yes - Mark (X) one
☐ Successive to previous plan
☐ Change of previous plan - Enter Date _____

15. Payment -This award is payable from the fund created by the following compensation law. Mark (X) one.
☐ Federal Employees' Compensation Act
☐ Longshore and Harbor Workers' Compensation Act
☐ District of Columbia Compensation Act

16. 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

17. 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 competing and review the collection of information. The obligation to respond to this collection is required to obtain or retain a benefit. 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.**