

Mail or fax to:  
 Department of Labor and Industry  
 Workers' Compensation Division  
 PO Box 64221  
 St. Paul, MN 55164-0221  
 (651) 284-5032 or 1-800-342-5354  
 Fax: (651) 284-5731

# Plan Progress Report



Print in ink or type  
 Enter dates in MM/DD/YYYY format

DO NOT USE THIS SPACE

1. Date of this report					
2. WID number or SSN		3. Date of injury			
4. Employee name					
5. Employee address					
City		State	ZIP code		6. Date of rehabilitation consultation: (#29 on R-2)
7. Employer name			8. Employer contact person		9. Phone number
10. Insurer claim number			15. QRC name		
11. Insurer/self-insurer/TPA			16. QRC firm		
12. Insurer address			17. Address		
City		State	ZIP code		City
State		ZIP code	City		State
City		State	ZIP code		City
13. Claim representative		14. Phone number		18. QRC #	19. QRC firm #
				20. Phone number	
21. Is the employee released to return to work? <input type="checkbox"/> Yes, with restrictions <input type="checkbox"/> Yes, without restrictions <input type="checkbox"/> No					Medical report date
22. Current work status: <input type="checkbox"/> Not working <input type="checkbox"/> Part time <input type="checkbox"/> Full time <input type="checkbox"/> Seasonal layoff					If working, is this a temporary job? <input type="checkbox"/> Yes <input type="checkbox"/> No
23. Is the plan still current? <input type="checkbox"/> Yes <input type="checkbox"/> No					
24. Costs		Plan costs to date	+	Other costs necessary to complete plan	= Estimated total cost
		<input type="text"/>		<input type="text"/>	= <input type="text"/>
25. Plan duration from plan filing date (in weeks)		Duration to date	+	Expected additional duration to plan completion	= Estimated total duration
		<input type="text"/>		<input type="text"/>	= <input type="text"/>
26. Do barriers to successful completion of the rehabilitation plan exist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, list these on a separate sheet along with the measures to be taken to overcome those barriers, and attach it to this form.					
QRC Signature		Date		QRC Intern Supervisor Signature	

This form is required to be filed 6 months after filing the R-2 (unless an R-3 is filed 15 days before or after 6 months have passed since the R-2 filing date). See Minnesota Rules 5220.0450, subp. 3 A. Send copies to the employee, insurer and attorney(s). Send to the date-of-injury employer if the goal of the rehabilitation plan is to return to work with that employer.

This form and access to the electronic submission format is located at [www.dli.mn.gov/WC/WcForms.asp](http://www.dli.mn.gov/WC/WcForms.asp). The form can be made available in different formats, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354.

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 Minnesota Statutes § 609.52, subd. 3.