

Rehabilitation Consultation Report



PRINT IN INK or TYPE
 ENTER DATES IN MM/DD/YYYY FORMAT

DO NOT USE THIS SPACE

1. WID or SSN		2. DATE OF INJURY			
3. EMPLOYEE NAME					
4. EMPLOYEE ADDRESS					
CITY		STATE	ZIP CODE	5. EMPLOYEE PHONE #	
6. EMPLOYER NAME			7. EMPLOYER CONTACT		8. EMPLOYER PHONE #
9. INSURER CLAIM NUMBER			14. QRC NAME		
10. INSURER/SELF-INSURER/TPA			15. QRC FIRM		
11. INSURER ADDRESS			16. QRC ADDRESS		
CITY		STATE	ZIP CODE	CITY	
STATE		ZIP CODE	STATE		ZIP CODE
12. CLAIM REPRESENTATIVE		13. CLAIM REP PHONE #		17. QRC #	18. QRC FIRM #
				19. QRC PHONE #	
20. In my opinion, the employee is permanently precluded or likely to be permanently precluded from engaging in the employee's usual and customary occupation or from engaging in the job the employee held at the time of injury. <input type="checkbox"/> Yes <input type="checkbox"/> No					
21. In my opinion, the employee is reasonably expected to return to suitable gainful employment with the date-of-injury employer. <input type="checkbox"/> Yes <input type="checkbox"/> No					
22. In my opinion, the employee is reasonably expected to return to suitable gainful employment through the provision of rehabilitation services, considering the treating physician's opinion of the employee's work ability. <input type="checkbox"/> Yes <input type="checkbox"/> No					
23. I have consulted with the date-of-injury employer regarding the above issues. <input type="checkbox"/> Yes <input type="checkbox"/> No					
24. Check Box A, B or C as applicable:					
<input type="checkbox"/> A. In my opinion the employee is a "qualified employee" and eligible for rehabilitation services at this time according to Minn. Rules 5220.0100, subp. 22.					
<input type="checkbox"/> B. In my opinion the employee is not a qualified employee and "is not" eligible to receive rehabilitation services at this time according to Minn. Rules 5220.0100, subp. 22.					
<input type="checkbox"/> C. The parties have informed me that they wish to initiate statutory rehabilitation services at this time.					
ATTACH A NARRATIVE REPORT EXPLAINING THE BASIS FOR YOUR DETERMINATION					
25. Date of first in-person or telephone meeting		QRC Signature or QRC Supervisor (if applicable)		QRC Intern Signature (if applicable)	

QRC: This form, along with a narrative report and the Rehabilitation Rights and Responsibilities of the Injured Worker form, must be received by the Department of Labor and Industry within 14 days of the date in Box 25 (the first in-person meeting or the first telephone conference) (Minn. Rule 5220.0130). If the employee is eligible for rehabilitation services, a Rehabilitation Plan (R-2) must be developed and circulated to the parties within 30 days of the initial meeting and filed with the Department within 45 days of the initial meeting (Minn. Rule 5220.0410).

Employee: If you disagree with or have questions about the information provided on this form, you are encouraged to contact the QRC and insurer to discuss any concerns. If your concerns are not resolved, you may call the Department at (651) 284-5032 or 1-800-342-5354, or request a determination by filing a Rehabilitation Request with the Department.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354/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.