Department of Labor and Industry
651-284-5030 or 800-342-5354

On the Job Training Plan

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

Reset

JA04

DO NOT USE THIS SPACE

Private or confidential data you supply on this form will be used to process your workers' compensation claim. 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.

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	
INSURER/SELF-INSURER/TPA	

INSURER CLAIM NUMBER	OJT JOB TITLE
OJT EMPLOYER NAME	OJT BEGINNING DATE
OJT EMPLOYER ADDRESS	OJT ENDING DATE
CITY STATE ZIP CODE	OJT PLAN PROGRESS EVALUATION DATE(S)

Does this OJT employer intend to hire the employee upon completion of the OJT? ☐ Yes ☐ No

JOB DESCRIPTION (attach a job analysis, or describe the nature of the work, giving examples of duties)

Job must be within the employee's physical restrictions. ATTACH MEDICAL REPORT.

List the skills the employee will acquire through this training:

List supplies and tools needed during training (itemize costs):

	TOTAL COSTS

WEEKLY WAGES AND WORKERS' COMPENSATION BENEFITS	**Start of OJT**	**End of OJT**
Weekly wages paid by OJT Employer		
Weekly workers' compensation benefits paid by Insurer		

RATIONALE FOR OJT: see Minn. Rule 5220.0850, subp. 2(N)
[NOTE: Justification is required for plans EXCEEDING 6 months: see Minn. Rule 5220.0850, subp. 3]

ACCEPTED PLAN: If all parties are in agreement with (and have signed) this OJT Plan, submit it to the Department with the required attachments for approval or denial (see Minn. Rule 5220.0850, subp. 4).

Employee Signature	Print or type name	Phone number	Date
Insurer Representative Signature	Print or type name	Phone number	Date
OJT Employer Signature	Print or type name	Phone number	Date
OJT Trainer Signature	Print or type name	Phone number	Date
QRC Signature	Print or type name	Phone number	Date
QRC Number			

INSTRUCTIONS TO QRC

DISPUTED PLAN: To resolve a disputed OJT Plan, call the Department's Benefit Management and Resolution Unit at (651) 284-5032, and/or file a Rehabilitation Request (see Minn. Rule 5220.0850, subp. 5). **DO NOT SUBMIT A DISPUTED PLAN to the Department without attaching it to a Rehabilitation Request, unless a Rehabilitation Request has been filed or will be filed by another party.**

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.

For Department Use Only

☐ Approved ☐ Denied			
DLI Representative Signature	Print or type name	Phone number	Date
Reason for denial:			