

INDIVIDUAL WRITTEN REHABILITATION PLAN (IWRP) ORIG: \_\_\_ AMEND: \_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
S.S.NO: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
D.O.I.: \_\_\_\_\_ EDUCATION LEVEL: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_ CARRIER: \_\_\_\_\_  
A.W.W.: \_\_\_\_\_ DATE OF VR REFERRAL: \_\_\_\_\_  
DISABILITY: \_\_\_\_\_

MEDICAL JUSTIFICATION FOR THE VOCATIONAL GOALS WITH THE ATTACHED MEDICAL REPORT:

LEVEL OF SERVICE:

VOCATIONAL GOAL WITH RATIONALE AND ESTIMATED WEEKLY EARNINGS:

DETAILED PLAN OF VOCATIONAL SERVICES INCLUDING THE NATURE AND EXTENT OF SERVICES AND THE PROJECTED DATES OF SERVICE:

EMPLOYEE AND REHABILITATION PROVIDER RESPONSIBILITIES FOR THE IWRP:

_____ EMPLOYEE SIGNATURE	_____ DATE	_____ EMPLOYER REPRESENTATIVE	_____ DATE
_____ REHABILITATION PROVIDER	_____ DATE	_____ LABOR DEPARTMENT	_____ APPROVAL DATE