PRIVATE VOCATIONAL REHABILITATION SERVICES QUARTERLY REPORT

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave.
P.O. Box 7901
Madison, WI 53707
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

The Quarterly Report should be completed for each WC claimant receiving return to work services from the certified specialist and submitted to the WC Rehabilitation Unit by the 5th day of the months April, July, October and January of each year.

Claimant Name	Social Security Number*
Provider Name	Provider Number
Provider Address	

CURRENT STATUS

Please check the appropriate boxes and fill in the blanks as requested.

- ☐ Denied private rehabilitation services by the carrier because
- ☐ Conducting Job Search
- ☐ In Retraining for _____ weeks in _____ program
- ☐ Employed (check the correct response)
  - 1. Same employer: ☐ Same job ☐ Different job
  - 2. Different employer
- ☐ Post injury wage _____ per week
- ☐ Post injury occupation _____
- ☐ No longer eligible, case fully compromised
- ☐ Claimant terminated relationship because _____
- ☐ Specialist terminated relationship because _____

CLOSURE INFORMATION

Please fill in the blanks and check the appropriate box as requested.

_____ Number of days in Job Search before placement

_____ Costs of Job Search phase, and _____ Hourly rate for service

_____ Number of weeks in Retraining

_____ Costs of services during or following retraining

Did your costs exceed the cap as determined per DWD 80.49(7)(e)? ☐ Yes ☐ No
If Yes, please describe what arrangements were made among all concerned parties to cover your fees?

Signature: _____ Date Signed: _____