Department of Labor
Workers' Compensation Division
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

DOL FORM VR227 Rev. 8/11

State File No. _____
Date of Injury _____
Ins. Co. File No. _____

Denial/Discontinuance of Vocational Rehabilitation by Employer or Carrier

Notice of this denial/discontinuance must be sent to the injured worker, vocational rehabilitation counselor and the Department of Labor.
Supporting evidence must be attached.

TO:
Claimant's Name: _____

Address: _____ Telephone No.: _____

Employer: _____ Date of Injury: _____

☐ Vocational Rehabilitation Denial ☐ Vocational Rehabilitation Discontinuance

Specify grounds for denial/discontinuance and give a brief statement of the specific facts supporting the grounds for denial/discontinuance. Attach ALL supporting documentation.

☐ DOCUMENTS ATTACHED

Basis for Denial/Discontinuance

A. ☐ No Lost Time/Medical Only

B. ☐ Return to Work Plan Not Reasonably Supported

C. ☐ Returned to Suitable Employment

D. ☐ Vocational Billing Not Reasonably Supported

E. ☐ Carrier was not provided an opportunity to participate in return to work plan development

F. ☐ Noncompliance with the Return to Work Plan:

G. ☐ Claim as a whole has been denied

H. ☐ Other (Specify): _____

Issued By:
Carrier: _____ Administrator (if not carrier): _____

Adjuster Name: _____ Telephone No. _____

Adjuster Signature: _____ Employer _____

Date Notice Sent to Claimant: _____

NOTICE and FORM for EMPLOYEE to CONTEST DENIAL/DISCONTINUANCE

TO CONTEST, COMPLETE THE INFORMATION BELOW **AND** ATTACH EVIDENCE TO SUPPORT YOUR POSITION. KEEP A COPY OF THE FORM FOR YOUR RECORDS AND MAIL A COPY OF THIS FORM TO the Department of Labor at the address above and the Insurance Carrier.

Has your insurer denied your workers' compensation claim?	Yes	_____	No	_____
Did you contest that denial?	Yes	_____	No	_____
Was an interim order issued by the Department	Yes	_____	No	_____
Did you lose time from work because of the injury?	Yes	_____	No	_____

If yes, on what date did you begin losing time from work? _____

If you have returned to work, indicate the date on which you returned. _____

Please attach any documents or information that you believe supports your claim for vocational rehabilitation benefits.

I am seeking all workers' compensation vocational rehabilitation benefits allowed by law. _____

_____
Employee Signature

If you have further questions please call or office at (802) 828-2286 or check our web-site at www.labor.vermont.gov

Equal Opportunity is the Law. The State of Vermont is an Equal Opportunity/Affirmative Action Employer. Applications from women, individuals with disabilities, and people from diverse cultural backgrounds are encouraged. Auxiliary aids and services are available upon request to individuals with disabilities. 711(TTY/Relay Service) or 802-828-4203 TDD (Vermont Department of Labor).