

**WEST VIRGINIA
WORKERS' COMPENSATION FUND
EMPLOYER'S ASSESSMENT OF
REHABILITATION NEEDS**

1. Claimant's Name	Please Complete and Return to: Workers' Compensation Fund Rehabilitation Services Section PO Box 3151 Charleston, WV 25332
2. SSN	
3. DOI	
4. Claim No.	
5. Employee returned to work on ____/____/____ and continued on the job. (Sign form below and return.)	
6. Date employment began ____/____/____	7. Most Recent Job Title
8. Total wages paid for the full twelve months prior to the month of the injury \$ _____ Note: If the injured worker was employed less than 12 months, provide us total wages paid during the course of his employment \$ _____	
9. Is the preinjury job still available upon physician release? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. If 'No' was checked in Section 9, please clarify _____ _____	
11. If the injured worker is released with some work activity restrictions, would you consider job modifications or alternate duties if those restrictions prohibited a return to the preinjury job duties? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Depends on the nature of the restriction	
12. In terms of physical/exertional requirements, we consider the preinjury job duties to be: <input type="checkbox"/> Very Heavy <input type="checkbox"/> Light <input type="checkbox"/> Heavy <input type="checkbox"/> Sedentary <input type="checkbox"/> Medium	13. In terms of skill level, we consider the preinjury duties to require an individual who is: <input type="checkbox"/> Highly Skilled <input type="checkbox"/> Semi-Skilled <input type="checkbox"/> Skilled <input type="checkbox"/> Unskilled
14. Comments: _____ _____ _____	
Employer Address	Signature Job Title Telephone Number
Thank you for your cooperation. Are you aware of other employees of your firm who might benefit from rehabilitation services? If so, please notify this department by separate correspondence at your earliest convenience.	