Reset Form Print Form

State of California
SETTLEMENT OF PROSPECTIVE VOCATIONAL REHABILITATION SERVICES [LC § 4646 (b)]

SSN (Numbers Only)

Case Number

Date of Birth: MM/DD/YYYY

Claim Number

(Choose only one)

☐ a specific injury on _____ MM/DD/YYYY

☐ a cumulative trauma injury which began on _____ (START DATE: MM/DD/YYYY) and ended on _____ (END DATE: MM/DD/YYYY)

Employee (All information in this section must be completed)

First Name MI

Last Name

Street Address /PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Phone

Employee's Attorney (All information in this section must be completed)

First Name MI

Last Name

Firm Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Phone

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Employer (All information in this section must be completed)

Employer Name (Please leave blank spaces between numbers, names or words)

Claim Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Employer's Representative (If Applicable)

First Name | MI

Last Name

Firm Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Phone

Qualified Rehabilitation Representative (if applicable)

First Name MI

Last Name

Firm Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Phone

In accordance with Labor Code section 4646 :

1. The parties to this agreement are the employee _____

and the employer or claims administrator _____

2. All parties agree that any vocational rehabilitation benefits paid and accrued prior to the date this agreement has been signed are separate and distinct funds from the amount settled in this agreement.

3. The parties hereby agree to settle the employee's right to prospective Vocational Rehabilitation services with a one-time payment to the employee for the sum of $ _____ , less the sum of $ _____ , as reasonable attorney's fee. The requested attorney's fee will be held in trust by the employer subject to approval and subsequent order by the Workers' Compensation Appeals Board.

4. The employee's attorney has fully disclosed and explained to the employee the nature and quality of the rights and privileges being waived and settled by the parties. The employee has knowingly and voluntarily agreed to relinquish his or her rehabilitation rights.

5. The employee understands and agrees that the settlement is to be applied to his/her self directed vocational rehabilitation, such as direct placement, training, self-employment. The Rehabilitation Unit shall approve or disapprove the settlement agreement of vocational rehabilitation. If disapproval is not made within ten (10) days of receipt of a fully executed agreement, the agreement shall be deemed approved. This Agreement is Final. Any aggrieved party must file an appeal with the Workers'
Compensation Appeals Board within twenty (20) days from the date this Agreement is approved, deemed approved or disapproved.

If Vocational Rehabilitation Services were commenced:

Summary of Services Provided

Number of weeks of VRMA _____

Total Amount of VRMA Paid $ _____

Total Amount of PD Supplement: $ _____

Amount Paid QRR for: $ _____

DOI's on or after 1/1/03

Phase A: $ _____

Phase B: $ _____

Total costs of QRR services $ _____

QRR Name _____

Total other costs of rehabilitation services: $ _____

Amount withheld for Employee's Representative, if any: $ _____

If plan developed, plan type: _____

Completed by: _____ Date: _____ MM/DD/YYYY

Employee's signature: _____ Date: _____ MM/DD/YYYY

Employee's Attorney's signature: _____ Date: _____ MM/DD/YYYY

Employer's Representative: _____ Date: _____ MM/DD/YYYY

Qualified Interpreter's signature: (If Needed) _____ Date: _____ MM/DD/YYYY

Interpreter's License Number: _____

Rehabilitation Unit
California Division of Workers' Compensation
Form RU-122
SETTLEMENT OF PROSPECTIVE VOCATIONAL REHABILITATION SERVICES

Purpose :

To record the agreement between the employee and the employer to settle prospective vocational rehabilitation services for injuries on or after 1/1/03.

Submitted by :

Any party.

When Submitted :

When the parties have agreed to settle prospective vocational rehabilitation services.

Where Submitted :

To the applicable Rehabilitation Unit district office. The Rehabilitation Unit's venue is the same as the WCAB. If no WCAB case exists, file with a Rehabilitation Unit within the county where the injured employee resides.

Form Completion :

Identifying data completed by claims administratorSignature of employee, employee's representative and claims administrator.

Accompanying documents :

None.

Rehabilitation Unit Action :

The Rehabilitation Unit shall either issue a determination based on the record, request additional information , or set the matter for formal conference.

Copy :

All parties.