

Nebraska Workers' Compensation Court

Vocational Rehabilitation Section

P.O. Box 98908

Lincoln, Nebraska 68509-8908

(402) 471-3606

(800) 599-5155

MAIL COMPLETED FORM TO ABOVE ADDRESS

OR FAX TO NE WCC VR SECTION AT (402) 742-8311



VR-42b

VOCATIONAL REHABILITATION COUNSELOR
APPOINTMENT REQUEST

EMPLOYEE NAME		DOCKET & PAGE NO. (IF APPLICABLE)
STREET ADDRESS		TELEPHONE NUMBER
CITY, STATE, ZIP CODE		EMPLOYEE EMAIL ADDRESS
EMPLOYER (NAME & ADDRESS)		DATE OF INJURY
INSURER (NAME & ADDRESS)		
CLAIM NUMBER (IF KNOWN)	CLAIM ADJUSTER	CLAIM ADJUSTER TELEPHONE NUMBER
TYPE OF INJURY		HAS EMPLOYEE RETURNED TO WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>
EMPLOYEE'S ATTORNEY (NAME & ADDRESS)		TELEPHONE NUMBER
EMPLOYER'S / INSURER'S ATTORNEY (NAME & ADDRESS)		TELEPHONE NUMBER
IS THE EMPLOYEE CLAIMING ENTITLEMENT TO VOCATIONAL REHABILITATION PURSUANT TO §48-162.01? YES <input type="checkbox"/> NO <input type="checkbox"/>	IS THE EMPLOYEE REQUESTING THAT VOCATIONAL REHABILITATION SERVICES BE PROVIDED? YES <input type="checkbox"/> NO <input type="checkbox"/>	IS THE REQUESTOR ASKING THAT A LOSS-OF-EARNING-POWER EVALUATION BE PERFORMED UNDER STATUTE 48-121(2)? YES <input type="checkbox"/> NO <input type="checkbox"/>
IS THE REQUESTOR ASKING THAT A LOSS-OF-EARNING-POWER EVALUATION BE PERFORMED FOR MULTIPLE SCHEDULED MEMBERS UNDER STATUTE 48-121 (3)? YES <input type="checkbox"/> NO <input type="checkbox"/>	IS AN INTERPRETER REQUIRED? YES <input type="checkbox"/> NO <input type="checkbox"/>	PRIOR TO THIS REQUEST, HAS ANY PARTY RETAINED THE SERVICES OF A VOC. REHAB. COUNSELOR FOR THIS CASE? YES <input type="checkbox"/> NO <input type="checkbox"/>
<p>A. The requestor attests that the employee has reached maximum medical improvement. YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>B. The requestor attests that the employee has permanent restrictions that are authored or endorsed by a physician. YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>C. The requestor attests that the employee has temporary restrictions that are authored or endorsed by a physician. YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>D. Describe in detail: (1) on what basis is the request for vocational rehabilitation counselor appointment being made; and (2) what steps the parties have taken in an attempt to agree on the selection of a vocational rehabilitation counselor. (Be sure to identify the names of the vocational rehabilitation counselors suggested by each party).</p>		
<p>NOTE: The requestor must provide the original or a copy of the VR-42b to the VR Section of the Workers' Compensation Court. Requestor must also provide a copy of this request to all parties. [Rule 42 (A)(3)]</p>		
PRINTED NAME OF REQUESTOR	SIGNATURE OF REQUESTOR	DATE SIGNED