Mail or fax to:
Department of Labor and Industry
Worker's Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354 Fax:
(651) 284-5731

Rehabilitation Consultation Report

PRINT IN INK or TYPE
ENTER DATES IN MM/DD/YYYY FORMAT

RC01

DO NOT USE THIS SPACE

1. WID or SSN	2. DATE OF INJURY		
3. EMPLOYEE NAME			
4. EMPLOYEE ADDRESS			
CITY	STATE	ZIP CODE	5. EMPLOYEE PHONE #

6. EMPLOYER NAME	7. EMPLOYER CONTACT	8. EMPLOYER PHONE #
9. INSURER CLAIM NUMBER	14. QRC NAME	
10. INSURER/SELF-INSURER/TPA	15. QRC FIRM	
11. INSURER ADDRESS	16. QRC ADDRESS	

CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE

12. CLAIM REPRESENTATIVE	13. CLAIM REP PHONE #	17. QRC #	18. QRC FIRM #	19. QRC PHONE #

20. In my opinion, the employee is permanently precluded or likely to be permanently precluded from engaging in the employee's usual and customary occupation or from engaging in the job the employee held at the time of injury. ☐ Yes ☐ No

21. In my opinion, the employee is reasonably expected to return to suitable gainful employment with the date-of-injury employer. ☐ Yes ☐ No

22. In my opinion, the employee is reasonably expected to return to suitable gainful employment through the provision of rehabilitation services, considering the treating physician's opinion of the employee's work ability. ☐ Yes ☐ No

23. I have consulted with the date-of-injury employer regarding the above issues. ☐ Yes ☐ No

24. **Check Box A, B or C as applicable:**

☐ A. In my opinion the employee is a "qualified employee" and eligible for rehabilitation services at this time according to Minn. Rules 5220.0100, subp. 22.

☐ B. In my opinion the employee is not a qualified employee and "is not" eligible to receive rehabilitation services at this time according to Minn. Rules 5220.0100, subp. 22.

☐ C. The parties have informed me that they wish to initiate statutory rehabilitation services at this time.

ATTACH A NARRATIVE REPORT EXPLAINING THE BASIS FOR YOUR DETERMINATION

25. Date of first in-person or telephone meeting	QRC Signature or QRC Supervisor (if applicable)	QRC Intern Signature (if applicable)

QRC: This form, along with a narrative report and the Rehabilitation Rights and Responsibilities of the Injured Worker form, must be received by the Department of Labor and Industry within 14 days of the date in Box 25 (the first in-person meeting or the first telephone conference) (Minn. Rule 5220.0130). If the employee is eligible for rehabilitation services, a Rehabilitation Plan (R-2) must be developed and circulated to the parties within 30 days of the initial meeting and filed with the Department within 45 days of the initial meeting (Minn. Rule 5220.0410).

Employee: If you disagree with or have questions about the information provided on this form, you are encouraged to contact the QRC and insurer to discuss any concerns. If your concerns are not resolved, you may call the Department at (651) 284-5032 or 1-800-342-5354, or request a determination by filing a Rehabilitation Request with the Department.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

cc: Employee, Employer, Insurer, and Attorney(s)