Vocational Return to Work Counselor (if any) (To Be Completed By Employee) (All information in this section must be completed)

First Name _____ MI _____

Last Name _____

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

City _____ State _____ Zip Code _____

Phone _____ Funds used for vocational and return to work counseling $ _____ (10% maximum of voucher value)

Training Provider Details (To Be Completed By Employee - Attach additional pages for each provider) (All information in this section must be completed) (Institutions must list their names in the first name box)

First Name _____

Last Name _____

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

City _____ State _____ Zip Code _____

Phone _____

Expiration Date _____ MM/DD/YYYY

Provider Approval Number _____

Provider Contact Name _____

Training Cost _____

The Injured Employee Must Sign and Date this Voucher Form

Injured Employee Signature _____

Date _____ MM/DD/YYYY

Note to Claims Administrator: Upon receipt of voucher, receipts and documentation from the employee, reimbursement payments to the employee or direct payments to VRTWC and training providers must be made within 45 calendar days.