

FORM 215-Insurer/Employer Request to Waive/Postpone Reemployment Referral

INSTRUCTIONS: Insurance carriers and employers may submit this form to request waiver or postponement of their obligation under **Section 34A-8a-302** of the Utah Injured Worker Reemployment Act to refer a disabled injured worker for rehabilitation or reemployment services. This form must be submitted to the Division of Industrial Accidents and also mailed to the injured worker within 10 day after submission of **Form 206 – Insurer/Employer Initial Reemployment Report for Injured Worker**. The Division will note its approval or disapproval on the bottom portion of this form and then mail a copy to the injured worker and to the WC insurance carrier or employer.

The Labor Commission rules and forms related to the Utah Injured Worker Reemployment Act can be found on the Division of Industrial Accidents' website at <http://laborcommission.utah.gov/IndustrialAccidents/index.html>

PLEASE PRINT OR TYPE (Please use MM/DD/YYYY for all dates)

Date FORM 215 submitted: ____/____/____ (MM/DD/YYYY)

Request for: waiver or postponement until ____/____/____ (MM/DD/YYYY)

Reason for waiver or postponement:

The injured worker is not medically stable.

The injured worker's physical capacity has not been determined. Please enter date by which you expect to obtain determination of physical capacity: Date: ____/____/____ (MM/DD/YYYY)

Liability for the injured worker's claim is under review. (Note: if waiver or postponement is requested for this reason, explain why it is not possible to refer the injured worker for the free services offered by the Utah State Office of Rehabilitation.)

Other reason(s) to request waiver or postponement of rehabilitation or reemployment referral:

Explanation: _____

Insurer or Employer's Name and Contact Information: _____

Contact's Name: _____ Telephone: (____)____ - _____

Contact's Signature: _____ Email: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Injured Worker's Full Name and Contact Information: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Date of Birth: ____/____/____ (MM/DD/YYYY) Social Security #: **XXX - XX -** _____ (four digits only)

Date of Injury: ____/____/____ (MM/DD/YYYY) Telephone: (____)____ - _____

SEND COMPLETED FORM to: Utah Industrial Accidents Division (mailing address shown below)

Approved

NOT approved

Date: ____/____/____ (MM/DD/YYYY)

Division of Industrial Accidents – Utah Labor Commission

Name: _____ Title: _____

Signature: _____



Form 215 Adopted October 14, 2009

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