FORM 206 – Insurer/Employer Initial Reemployment Report for Injured Worker

INSTRUCTIONS: ***§34A-8a-301*** *of the Injured Worker Reemployment Act requires insurance carriers or employers to prepare and submit this Form 206 within 30 days after it appears that: 1) an injured worker is or will be a "disabled injured worker as defined in* ***§34A-8a-102(1)*** *of the Act; or 2) the injured worker's temporary total disability compensation period exceeds 90 days.*

Within 10 days after submitting this Form 206 the insurance carrier or employer must either refer the injured worker to the Utah Office of Rehabilitation or a private rehabilitation/reemployment service; or request postponement or waiver of the referral requirement by submitting Form 215 to the Division of Industrial Accidents (IAD).

The Utah Labor Commission rules and forms related to the Utah Injured Worker Reemployment Act can be found on the IAD website at ***http://laborcommission.utah.gov/IndustrialAccidents/index.html****.*

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

CONTACT INFORMATION SS#: **XXX** - **XX** -_____(last four digits only)

Employee's Full Name:_____ Date of Injury____/____/____

Address:_____ Date of Birth ____/____/____

City:_____State:_____Zip:_____Telephone Number: (____0_____

Occupation of Injured Worker:_____ Pre-Injury Weekly Wage: $_____

Employer – Name & Contact Information:

_____

Insurance Carrier – Adjustor's Name & Contact Information (if applicable):

_____

Rehabilitation or Reemployment Service Provider - Name & Contact Information (if applicable):

_____

☐ **A. Reemployment Assistance is NECESSARY**

Check "A" if reemployment assistance is needed; also check the recommended services:

- ☐ Counseling
- ☐ Vocational Evaluation
- ☐ Job Placement
- ☐ Job Seeking Skills
- ☐ Reemployment Plan
- ☐ On the Job Training
- ☐ Transferable Skills Analysis
- ☐ Jobsite Modification
- ☐ Coordinate Reemployment
- ☐ Retraining
- ☐ Other: _____

Referral for reemployment services:

Provider:_____

Counselor_____

Referral Date____/____/____

☐ **B. Unable to Determine Need or Proceed with Assistance**

Check "B" if any of the following are true; also check appropriate response below. You must submit Form 215 within 10 days to obtain IAD's approval to waive or postpone the referral.

- ☐ Not medically stable
- ☐ Physically capacity has not been determined
- ☐ Claim liability is under review

☐ **C. Employment Assistance is NOT NECESSARY**

Check "C" if reemployment assistance is NOT necessary (specify reasons below):

- ☐ Worker returned to work (RTW):
  - ☐ Same Employer
  - ☐ New Employer
  - ☐ Self Employed
  - ☐ Same Job
  - ☐ New Job
  - ☐ Modified Job
- ☐ Worker RTW as a result of vocational rehabilitation support services
- ☐ Disability too severe to return to work
- ☐ Other (specify):_____

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Industrial Accidents Division

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