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DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION

DOL FORM 22 (Rev. 6/10)

State File No. _____

Ins. Co. File No. _____

Date of Injury _____

AGREEMENT FOR PERMANENT PARTIAL or PERMANENT TOTAL DISABILITY COMPENSATION

IT IS AGREED, between _____, the employee,
whose address is: _____
and _____, the insurance carrier/employer, that the employee suffered an accident while in the employ of _____
and that the employee sustained the following injury: _____
which resulted in temporary total disability beginning on _____, 20 _____ or [] no lost time.

WEEKLY COMPENSATION RATE

Employee's average weekly wage (AWW) before the accident was \$ _____ S/he is entitled to compensation at the rate of 66 2/3
percent of said AWW or \$ _____ per week. This is updated on July 1 of each year and is now \$ _____ per week.
A transcript of the employee's wages for the twelve weeks was previously submitted or is attached.

Day of the week the check will be mailed to the claimant or deposited in the claimant's account _____

MEDICAL, HOSPITAL AND SURGICAL SERVICES

That the employee shall receive medical services and supplies in accordance with 21 VSA§640.

PERMANENT PARTIAL or PERMANENT TOTAL DISABILITY

Employee is entitled to: Permanent Partial Disability _____ Permanent Total Disability _____

At the end of temporary total or temporary partial, on the _____ day of _____ 20 _____ the employee having either
[] returned to work or [] reached an end medical result for which a discontinuance, Form 27 was filed on _____

The impairment rating is _____. This impairment represents a payment of compensation benefits for a period of _____ weeks.
The impairment rating is based upon the following medical report: _____ Dr. _____

If payment is to be in a lump sum please complete one of the paragraphs below:

Claimant agrees to accept and the employer/carrier agrees to pay a lump sum of \$ _____. This lump sum is compensation for
permanent impairment that will affect the claimant for the rest of his/her life. The claimant's remaining life expectancy is _____ years
or _____ months. Therefore, even though paid in a lump sum, claimant's benefit (after deduction of attorney fees
of _____ and expenses of _____) shall be considered to be _____ /months \$ _____ per month
beginning on the date of approval of this settlement

OR

Claimant agrees to accept and the employer/carrier agrees to pay a lump sum of \$ _____. Claimant expressly requests that
the lump sum not be prorated as otherwise required by 21 V.S.A. §652(c)

The employee is entitled to seek an opinion on permanent impairment from his/her treating physician

APPROVAL AND REVIEW

This agreement is subject to review by the Commissioner and shall not be binding or operative until approved.

Insurance Adjuster Name (Print) _____

Employee Signature _____ Date _____

Insurance Adjuster Signature _____

Official Title _____ Date _____

APPROVED: _____ Date _____

Commissioner of Labor/Designee _____