



**Department of Labor**  
**Workers' Compensation Division**  
 5 Green Mountain Drive, PO Box 488  
 Montpelier, VT 05601-0488  
 (802) 828-2286

DOL FORM VR227 Rev. 8/11

State File No. \_\_\_\_\_  
 Date of Injury \_\_\_\_\_  
 Ins. Co. File No. \_\_\_\_\_

**Denial/Discontinuance of Vocational Rehabilitation by Employer or Carrier**

Notice of this denial/discontinuance must be sent to the injured worker, vocational rehabilitation counselor and the Department of Labor.  
**Supporting evidence must be attached.**

**TO:**  
 Claimant's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone No.: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Vocational Rehabilitation Denial  Vocational Rehabilitation Discontinuance

Specify grounds for denial/discontinuance and give a brief statement of the specific facts supporting the grounds for denial/discontinuance. Attach ALL supporting documentation.

DOCUMENTS ATTACHED

**Basis for Denial/Discontinuance**

- A.  No Lost Time/Medical Only

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- B.  Return to Work Plan Not Reasonably Supported

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- C.  Returned to Suitable Employment

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- D.  Vocational Billing Not Reasonably Supported

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- E.  Carrier was not provided an opportunity to participate in return to work plan development

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- F.  Noncompliance with the Return to Work Plan:

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- G.  Claim as a whole has been denied

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- H.  Other (Specify): \_\_\_\_\_

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**Issued By:**  
 Carrier: \_\_\_\_\_ Administrator (if not carrier): \_\_\_\_\_  
 Adjuster Name: \_\_\_\_\_ Telephone No. \_\_\_\_\_  
 Adjuster Signature: \_\_\_\_\_ Employer \_\_\_\_\_

Date Notice Sent to Claimant: \_\_\_\_\_

**NOTICE and FORM for EMPLOYEE to CONTEST DENIAL/DISCONTINUANCE**

TO CONTEST, COMPLETE THE INFORMATION BELOW **AND** ATTACH EVIDENCE TO SUPPORT YOUR POSITION. KEEP A COPY OF THE FORM FOR YOUR RECORDS AND MAIL A COPY OF THIS FORM TO the Department of Labor at the address above and the Insurance Carrier.

Has your insurer denied your workers' compensation claim?	Yes	_____	No	_____
Did you contest that denial?	Yes	_____	No	_____
Was an interim order issued by the Department	Yes	_____	No	_____
Did you lose time from work because of the injury?	Yes	_____	No	_____
If yes, on what date did you begin losing time from work?	_____			
If you have returned to work, indicate the date on which you returned.	_____			

Please attach any documents or information that you believe supports your claim for vocational rehabilitation benefits.

I am seeking all workers' compensation vocational rehabilitation benefits allowed by law. \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

If you have further questions please call or office at (802) 828-2286 or check our web-site at [www.labor.vermont.gov](http://www.labor.vermont.gov)

**Equal Opportunity is the Law. The State of Vermont is an Equal Opportunity/Affirmative Action Employer. Applications from women, individuals with disabilities, and people from diverse cultural backgrounds are encouraged. Auxiliary aids and services are available upon request to individuals with disabilities. 711(TTY/Relay Service) or 802-828-4203 TDD (Vermont Department of Labor).**