File this form with the Department of Labor and Industry at the address or fax number listed at the end of this form.

THIS FORM RESPONDS TO ISSUES RAISED ON THE REHABILITATION REQUEST FORM SIGNED ON _____ (date)

Rehabilitation Response

PRINT IN INK or TYPE
ENTER DATES in MM/DD/YYYY FORMAT

Reset

RR03

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	PHONE # (include area code)

EMPLOYEE ADDRESS			INSURER/SELF-INSURER/TPA		
CITY	STATE	ZIP CODE	INSURER ADDRESS		
EMPLOYER NAME			CITY	STATE	ZIP CODE
EMPLOYER ADDRESS			CLAIM REPRESENTATIVE NAME		
CITY	STATE	ZIP CODE	INSURER CLAIM #	INSURER PHONE #	EXT

INSTRUCTIONS:

- All parties are expected to try to resolve issues themselves, using the Department of Labor and Industry to settle disputes only when these attempts fail.
- This form must be filled out completely.
- The injured worker's name, WID or social security number, and date of injury must be written on all attached documents.
- Insurers must file this form with the Department of Labor and Industry, and serve this form on the other parties, within 10 days after service of the Rehabilitation Request. All others should file this form with the Department of Labor and Industry, and serve it on all parties, within 20 days after service of the Rehabilitation Request.

I AM INTERESTED IN TRYING TO RESOLVE ISSUES INFORMALLY THROUGH MEDIATION.
For more information, call the Alternative Dispute Resolution Unit at (651) 284-5032 or 1-800-342-5354. ☐ **YES** ☐ **NO**

1. **THIS RESPONSE IS BEING COMPLETED BY:**

☐ Employee ☐ Employee's Attorney ☐ Employer ☐ Insurer/TPA Self-insured ☐ Insurer's Attorney ☐ QRC/ Vendor

2. **RESPONSE TO ISSUES RAISED ON REQUEST FORM (check only those that apply)**

a. I ☐ agree ☐ disagree with the request for rehabilitation consultation/services.

IF A QRC IS BEING ASSIGNED, GIVE NAME AND ADDRESS AND INDICATE WHO SELECTED THE QRC.

NAME	FIRM NAME	ADDRESS	SELECTED BY

b. I ☐ agree ☐ disagree with the request to change QRCs.

c. I ☐ agree ☐ disagree that the rehabilitation plan should be changed.

d. I ☐ agree ☐ disagree with the request for retraining/exploration of retraining.

e. I ☐ agree ☐ disagree that the rehabilitation plan should be terminated.

f. I ☐ agree ☐ disagree that the rehabilitation plan should be suspended.

g. I ☐ agree ☐ refuse to reimburse the employee for rehabilitation expenses.

h. I ☐ agree ☐ refuse to pay the requested QRC/vendor bills. Attach list of service charges disputed and reasons for dispute.

i. Response to "Other":

YOU MUST COMPLETE # 3 BELOW IF YOU DISAGREE WITH ANY PART OF THE REQUEST.

3. Explain why you disagree with the request and why it should not be granted. Attach extra sheets if necessary. You must attach medical reports, QRC/vendor reports or other documents which are needed to support your position. A written decision may be based solely upon review of this form, its attachments, the Workers' Compensation Division file, and the Rehabilitation Request form.

4. Send a copy of this form and all attachments to all parties, including the employee, employer, insurer, QRC/vendor, and attorneys. Provide the names and addresses below. Attach extra sheets if necessary.

NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE

I sent a copy of this form and all attachments to the parties listed in #4 on _____ (date)

PRINT NAME OF PERSON FILING THIS RESPONSE			SIGNATURE		
ADDRESS			ATTORNEY REGISTRATION #		
CITY	STATE	ZIP CODE	PHONE # (include area code)	EXT	DATE SIGNED

WHEN YOU HAVE FULLY COMPLETED THIS FORM, RETURN IT AND ALL ATTACHMENTS TO:	**In Person:** MN Department of Labor and Industry Workers' Compensation Division 443 Lafayette Road N. St. Paul, MN 55155-4301	**Mailing Address:** MN Department of Labor and Industry Workers' Compensation Division PO Box 64221 St. Paul, MN 55164-0221	**Fax:** 651-284-5731

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.