



REHABILITATION SERVICES COMMISSION REFERRAL

INSTRUCTIONS:

- Please print or type.
- Make sure to enter 4 digits for the year in all date fields.
- If you have any questions, please call the customer service team representative assigned to the claim.
- Follow the distribution list at the bottom of the form.

NOTE: Your acceptance of the injured worker below qualifies your agency for reimbursement of the State portion of its expenditures in accordance with the agreement between the RSC and BWC, effective June 10, 1985.

This referral is in accordance with Section 4121.69(B) and (C) of the Ohio Revised Code and the BWC Rule 4123-18-13.

Injured worker name (Last)	(First)	(M.I.)	Social Security Number	Claim number
Address				Telephone number ()
City			State	9-digit ZIP Code
County	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth	Date of injury
Allowable conditions _____				
Referral source (Check one) <input type="checkbox"/> MCO case manager <input type="checkbox"/> Vocational Rehabilitation Consultant				Date of referral
Reason for referral _____ _____				
MCO name	MCO case manager name		Case manager telephone number ()	
BWC service office	Vocational Rehabilitation Consultant name		Consultant telephone number ()	
RSC agency (Check one) <input type="checkbox"/> BSVI <input type="checkbox"/> BVR	RSC counselor name		RSC counselor telephone number ()	
Address (location of RSC counselor)				
City			State	9-digit ZIP Code

Distribution: BWC claim file, Injured worker, injured worker representative, Employer, Employer representative, MCO