



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

**PHYSICIAN'S REHABILITATION
INFORMATION SHEET**

P.O. Box 58
Jefferson City, MO 65102-0058
573-751-4231
labor.mo.gov/DWC

The purpose of this form is to gather additional information to determine eligibility for physical rehabilitation benefits for the indicated injured employee. **Please note** the date of injury and complete the form according to the patient's condition at the time of the injury or initiation of rehabilitation. (The condition at the time of injury and rehabilitation may be different from present condition).

Employee: _____

Employer: _____

Injury No: _____

Insurer's No: _____

Attending Physician: _____

Complete Mailing Address: _____

Phone Number: _____

Rehabilitation has been received: ☐ Yes ☐ No

Rehabilitation is currently being received: ☐ Yes ☐ No

Rehabilitation is expected to be received: ☐ Yes ☐ No

No rehabilitation received or indicated: ☐ Yes ☐ No

Insurance contact person for this claim:

Name: _____

Phone Number: _____

Return completed form to:

Fax: 573-522-1623

**Mail: Attn: Physical Rehabilitation
Missouri Division of Workers' Compensation
P. O. Box 58
Jefferson City, MO 65102-0058**

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711