



## Alternative Vocation Program Referral

### Referral Date: Injured Worker & Physician Information

|                                                                                                                                                                                    |                                    |                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------|
| <b>IW Name:</b>                                                                                                                                                                    | Date of Injury:                    | State Jurisdiction: |
| Address:                                                                                                                                                                           | Type of Injury (back, ankle, etc): | Language:           |
| City: State: Zip:                                                                                                                                                                  | <b>Treating Physician:</b>         |                     |
| Occupation: Age:                                                                                                                                                                   | Address:                           | Phone #:            |
| AWW: \$ Comp Rate: \$                                                                                                                                                              | City: State: Zip:                  |                     |
| Home #: Cell #:                                                                                                                                                                    | FCE Date: IME Date: MMI Date:      |                     |
| Email:                                                                                                                                                                             | Date of Restrictions:              |                     |
| Specific Restrictions:                                                                                                                                                             |                                    |                     |
| <b>WORK LEVEL:</b> <input type="checkbox"/> SEDENTARY <input type="checkbox"/> LIGHT <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OTHER |                                    |                     |

### Employer & Carrier with Billing Information

|                       |                   |          |
|-----------------------|-------------------|----------|
| <b>Employer Name:</b> | <b>Carrier:</b>   | Claim #: |
| Contact:              | Adjuster:         | Phone #: |
| Address:              | Address:          |          |
| City: State: Zip:     | City: State: Zip: |          |
| E-Mail:               | E-Mail:           |          |

### Attorney Information

|                     |                          |
|---------------------|--------------------------|
| <b>IW Attorney:</b> | <b>Defense Attorney:</b> |
| Firm:               | Firm:                    |
| Address:            | Address:                 |
| City: State: Zip:   | City: State: Zip:        |
| Phone #: File #:    | Phone #: File #:         |
| Email:              | Email:                   |

**Enclosures:**

**Fax completed form to 312-254-3258 or email to dan@varnerclaimsconsulting.com**

Momentum Healthcare, Inc  
 PO Box 19425  
 Jacksonville, FL 32245  
 904.721.6700  
[www.momentumhealthcare.com](http://www.momentumhealthcare.com)

Varner Claims Consulting, LLC  
 1749 Golf Road #378  
 Mt. Prospect, IL 60056  
 312.450.3259  
[www.varnerclaimsconsulting.com](http://www.varnerclaimsconsulting.com)