Offsite Alternative Light Duty Work Assignment
Referral Information

Referral Date:	**Injured Employee Information**
Name:	Date of Injury:
Address:	Type of Injury (back, ankle, etc):
City: State: Zip:	Claim #:
Occupation: Age:	State Jurisdiction:
Languages spoken:	Hourly Rate to be Paid while in ALD:
Non-profit earliest start date availability:	Date of Restrictions: By Physician:
Gender: Male Female	Next Doctors Appointment:
Specific Restrictions:	

Employer Information

Employer Name: /	**Email Alert Notification for Electronic Timecard to:**
Contact:	Email:
Address:	Email:
City: State: Zip:	Timecard Supervisor:
Phone:	**Claim Adjuster:** Phone:
E-Mail:	E-Mail:

Hours Worked per Week pre-injury: Any transportation issues & what are they:

VCC to send work assignment letter to injured employee: Yes No If yes, provide attorney information, if applicable

Comments:

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

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