

NOTICE OF TERMINATION OF VOCATIONAL REHABILITATION SERVICES			Rehabilitation Use Only	
Social Security Number		WCAB Number		Rehab Unit Number
Employee Name (Last)		(First)	(MI)	Date of Birth
Address (Street)		(City)	(State)	(Zip)
Employer Name			Insurance Company Name; Or, if Self-Insured, Certificate Name	
Address			Adjusting Agency Name (if adjusted)	
City, State, Zip			Claims Mailing Address	
Date of Injury	Claim Number		City, State, Zip	Phone No.
Employee Representative			Employer Representative	
Firm Name			Firm Name	
Address			Address Phone No.	
City, State, Zip		Phone No.	City, State, Zip	
Qualified Rehabilitation Representative				
Firm Name			Representative Name	
Address (Street, City, State, Zip)			Phone No.	

CLOSURE REASONS (Check one box which applies)

- 1. The employee declines and has signed the RU-107 or RU-107A.
- 2. The qualified employee completes a vocational rehabilitation plan.
- 3. The qualified employee unreasonably fails to complete a vocational rehabilitation plan.
- 4. The employee has not requested vocational rehabilitation within 90 days.
- 5. The employer offers and the employee accepts/rejects modified work lasting 12 months, even if the employee voluntarily quits prior to the end of the 12 month period. *(Attach RU-94)*
- 6. The employer offers and the employee accepts/rejects alternative work meeting all of the conditions listed in Labor Code §4644(a)(6). Attach RU-94.
- 7. The employer offers and the employee accepts a job not meeting criteria of #5 or #6. *(Attach RU-94)*

NOTICE TO EMPLOYEE

If you agree with the above, no further action is required on your part, and we will not be providing vocational rehabilitation services in the future.

If you disagree with our determination that we have no further liability to provide vocational rehabilitation services, you or your representative must submit your written objections and the reasons for them to the Rehabilitation Unit within twenty (20) days of receipt of this Notice. The form to use to make your objection is enclosed. Be sure to send a copy to me. The Rehabilitation Unit will then determine if you are to be given further services. Please send a copy of this Notice, with your objection, to the Rehabilitation Unit located at: *(insert Rehabilitation Unit address)*

If you have any questions about this notice, you may contact me at: _____.

SUMMARY OF SERVICES PROVIDED

Number of weeks of VRMA: (Within the cap) \$ _____ Total Amount of paid VRMA: (Within the cap) \$ _____ Total Amount of PD supplement: \$ _____ Amount Paid for QRR: \$ _____	RU-94 Offer <input type="checkbox"/> Modified Job (L.C. 4644 (a)(5)) <input type="checkbox"/> Alternate Job (L.C. 4644 (a)(6)) <input type="checkbox"/> "Other Job" (L.C. 4644 (a)(7)) Did employee RTW? Yes _____ No _____ If Yes, employee's new job title: _____ Wages: \$ _____ per _____ (Hour/Week/Month)
<p align="center">DOIs on/after 1/1/94</p> VR initiated before 1/1/98 VR initiated on/after 1/1/94 Phase I: \$ _____ Phase A: \$ _____ Phase II: \$ _____ Phase III: \$ _____ Phase B: \$ _____ Total Cost of QRR Services: \$ _____ QRR Name: _____ Total Cost of Other VR Services: \$ _____ Amt. Withheld for Employee's Attorney (if any) \$ _____	Plan Completion Plan Type <input type="checkbox"/> Direct Placement <input type="checkbox"/> OJT <input type="checkbox"/> Training <input type="checkbox"/> Self Employment <input type="checkbox"/> Modified Job <input type="checkbox"/> Alternate Job Employed in Plan Objective: Yes _____ No _____ If Yes, employee's new job title: _____ Wages: \$ _____ per _____ (Hour/Week/Month)

PROOF OF SERVICE BY MAIL

I am a citizen of the United States and a resident of the County of: _____ . I am over the age of eighteen years and not a party to the within matter. My business address is: _____ .

On _____, I served the Notice of Termination of Vocational Rehabilitation Services on the parties listed below by placing a true copy thereof enclosed in a sealed envelope with postage fully prepaid, and thereafter deposited in the U.S. Mail at the place so addressed.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed at _____ on _____ 20____.

Signature

Copies Served On:

**Rehabilitation Unit
California Division of Workers' Compensation**

RU-105

NOTICE OF TERMINATION OF REHABILITATION SERVICES

Purpose:

To notify the employee of the employer's termination of liability to provide rehabilitation services. It is not to be used for non-feasibility. This notice is not to be used for injuries prior to 1990.

Submitted by:

Claims Administrator to the injured employee and representative.

When submitted:

Within 10 days of the circumstances set forth in LC §4644(a).

Where submitted:

Original of the notice is sent to the employee and a copy to the applicable Rehabilitation Unit district office. The Rehabilitation Unit's venue is the same as the WCAB. If no WCAB case exists, file with a Rehabilitation Unit within the county where the injured employee resides.

Accompanying documents:

- ◆ RU-94 for DOI's on or after 1/1/94 where an offer of modified or alternate work has been accepted or rejected.
- ◆ Agreed upon plans for represented injured workers whose date of injury is on or after 1/1/94. (See 1994-1999 rules - AR 10126b(3))
- ◆ All declination forms and *Notice of Potential Eligibility*.
- ◆ A copy of proof of service.

Rehabilitation Unit action:

When the employee objects to the notice of termination, the Rehabilitation Unit will hold a conference or otherwise obtain the employee's reason for objection and issue its decision.

Notes: Copies of medical or vocational reports are not required to be submitted to the Rehabilitation Unit when filing a copy of the RU-105 on injuries subsequent to 1/1/90.

All RU-105 Notices must have a "Proof of Service" as required by AR 10131(a). For further information of "Proof of Service" see 8 Cal 10514.