14-0009 (11/06) (TYPE OR PRINT)

FORM 100B BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

Claimant_____

VS.

Employer_____

Street_____

City_____State_____Zip_____

Insurance Carrier_____

Street_____

City_____State_____Zip_____

File Number_____

ORIGINAL NOTICE, PETITION, ANSWER AND ORDER CONCERNING

VOCATIONAL REHABILITATION PROGRAM BENEFIT (Iowa Code Section 85.70)

Injury Date_____

Body Part(s) Injured_____

ORIGINAL NOTICE

To the Above-Named Employer:

You are notified that an action has been commenced before the Iowa Workers' Compensation Commissioner seeking relief as set forth in the petition below. You are required to file and serve an answer to the petition **(SEE REVERSE SIDE OF FORM) within 20 days following your receipt of this document or to otherwise move or respond as provided by Division of Workers' Compensation rules. Failure to comply may result in the imposition of sanctions under rule 876 IAC 4.36 and/or entry of a default and an award for the relief requested. NOTE:** You should promptly advise your workers' compensation insurance carrier and attorney that you have received this notice.

PETITION **(To Be Completed By Claimant and Vocational Rehabilitation Counselor)**

Claimant requests a vocational rehabilitation program benefit in accordance with Iowa Code section 85.70, as follows:

Training Facility_____
NAME CITY STATE

Type of Training_____

Training will be for _____weeks, commencing_____, _____.

This training is part of a vocational rehabilitation program recognized by the State Board for Vocational Education. Completion of the program will likely accomplish rehabilitation.

Signature of Rehabilitation Counselor_____Date Signed_____Phone ( ) _____

IN SUPPORT of this request claimant states:

1. Claimant sustained injury arising out of and in the course of employment with the employer on (Date)_____
2. The injury occurred at (City) _____ (County) _____ (State)_____
3. Claimant has not returned to gainful employment and cannot do so because of permanent disability resulting from the injury as shown by the attached medical report.
4. Evidentiary hearing under Iowa Code section 17A.12 is waived.

I, (Claimant's Signature) _____, ***Date Signed***_____

certify, under penalty of perjury and pursuant to the laws of the State of Iowa, that the preceding petition is true and correct.

Claimant's Phone No. (Include Area Code)_____

(If Represented by Attorney)

Attorney_____

Street_____

City_____State_____Zip_____

Phone (Include Area Code)_____

Fax Number (Include Area Code) _____

_____
Signature of Attorney

_____
Email Address of Attorney

THE INFORMATION PROVIDED WILL BE OPEN FOR PUBLIC INSPECTION UNDER IOWA CODE § 22.11

_____VS. _____File No,._____
Claimant Employer

PROOF OF SERVICE

On the _____day of_____, _____, I mailed a copy of the foregoing original notice and petition by certified mail, return receipt requested, to the employer's last known address which is

_____

I CERTIFY under penalty of perjury and pursuant to the laws of the State of Iowa that the preceding is true and correct.

Date_____ Signature _____

ANSWER (Employer/Insurance Carrier must answer on this form)

1. Employer/Insurance Carrier admit all allegations of the petition except those contained in paragraphs (Enter numbers)_____which are expressly denied.
2. Employer/Insurance Carrier consent to pay the requested rehabilitation benefit.
3. Evidentiary hearing under Iowa Code section 17A.12 is waived.

On behalf of the employer and insurance carrier and based upon my own knowledge of the circumstances, I certify under penalty of perjury and pursuant to the laws of the State of Iowa that the preceding answer is true and correct. Date:_____

Employer _____ _____
Signature of Person Answering
Street _____ Name _____
City _____State _____Zip _____ Title _____
Phone (Include Area Code) _____ (If Represented by Attorney)
Insurer: _____ Attorney _____
Street_____ Street _____
City_____State_____Zip_____ City _____State_____Zip_____
Phone (include Area Code)_____ Phone (Include Area Code)_____

ORDER (Completed by the deputy workers' compensation commissioner)

☐ **The allegations of the petition are found to be true.**
☐ **The application is granted. Employer/Insurance Carrier shall pay claimant the requested vocational rehabilitation benefit of $20.00/$100.00 per week for _____ weeks commencing when the training commences.**
☐ **The application is denied.**
Reason:_____
☐ **The application will be scheduled for an evidentiary hearing. You will be mailed notice of the time and location of the hearing.**

Signed and filed this_____day_____, _____

Deputy Workers' Compensation Commissioner _____

Copies To: Attorney(s) at Law or Pro Se_____ Attorney(s) at Law or Pro Se_____

INSTRUCTIONS - BOTH PARTIES MUST USE THIS FORM

To Claimant:

1. Have your Vocational Rehabilitation Counselor complete the first part of this form.
2. You must attach to this form a copy of the physician's report which shows that the injury caused permanent disability which prevents you from returning to gainful employment and the claimant's confidential information sheet.
3. Deliver a copy of this form with the front page completed and the physician's report to the employer by certified mail, return receipt requested or by personal service as in civil actions (rule 876 IAC 4.7) and mail a copy to the employer's attorney of record for this file if known (rule 876 IAC 4.13).
4. Complete the proof of service portion of the original of this form and deliver this entire form with the physician's report to the Division of Workers' Compensation at 1000 East Grand Avenue, Des Moines, Iowa 50319-0209.
5. If you desire an evidentiary hearing, delete paragraph "4" of the petition and in its place enter "I request a hearing." Rule 876 IAC 4.4.
6. The benefit is $20.00 per week, $100 for injuries after September 6, 2004, not to exceed 26 weeks.

To Employer/Insurance Carrier:

1. Enter the number of each paragraph of the petition which is denied in the space provided in paragraph "1" of the answer.
2. If you do not consent to the requested rehabilitation benefit, delete paragraph "2" of the answer.
3. If you desire an evidentiary hearing, delete paragraph "3" of the answer and in its place enter "I request a hearing. " Rule 876 IAC 4.4.
4. Serve a copy of your answer to the claimant or claimant's attorney pursuant to rule 876 IAC 4.13.
5. Type or print the name and title of the person answering below the signature.

IOWA WORKFORCE DEVELOPMENT