N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
VOCATIONAL REHABILITATION

REQUEST FOR WORKERS' COMPENSATION COVERAGE

The following information is required to request coverage for an Individual of services of the Division of Services for the Blind (DSB) Vocational Rehabilitation (VR) Program prior to the individual beginning work. All data required.

NAME OF WORKER OR INDIVIDUAL: _____

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH:** _____

EMPLOYER: _____

ADDRESS: _____

_____ **PHONE:** _____

WORKER'S/INDIVIDUAL'S JOB TITLE OR DESCRIPTION OF DUTIES: _____

_____

BEGIN COVERAGE (date): _____ **END COVERAGE (date):** _____

TOTAL NUMBER OF DAYS OF COVERAGE: _____

NUMBER OF HOURS OF WORK PER DAY: _____

Worker/individual has been advised of Workers" Compensation coverage and understands to report any and all injuries, no matter how insignificant, to the available supervisor/manager at the worksite AND to the Vocational Rehabilitation (VR) staff member within 24 hours of occurrence.

COVERAGE REQUESTED BY: _____
(DSB Staff Member Signature)

DATE: _____