BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant(s), vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	No(s).: _____ _____ **Original Notice & Petition Concerning Vocational Rehabilitation Program Benefit**

TO THE ABOVE-NAMED DEFENDANT(S):

- You are notified that the above-named claimant filed with the Iowa Division of Workers' Compensation (DWC) this original notice and petition naming you as the defendant(s).
- You must file with DWC an answer or otherwise respond within 20 days of receipt of this document. If you do not, the DWC may enter judgment by default against you for the relief demanded in the petition or impose sanctions under Iowa Administrative Code rule 876—4.36.
- You are advised to seek legal advice at once to protect your interests. If applicable, you should promptly notify your workers' compensation insurance carrier.

PETITION

1. Employer's address: _____
2. Insurance carrier's address : _____
3. Claimant sustained injury arising out of and in the course of employment with the employer on:

   _____
4. Claimant's injury occurred in the following city, county, and state:

   City: _____ County: _____ State: _____
5. 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.
6. Claimant requests a vocational rehabilitation program benefit under Iowa Code section 85.70(1) as follows:
   a. Training Provider Name: _____
   b. Training Provider Location: _____
   c. Type of Training: _____
   d. Start Date of Training: _____
   e. Duration of Training: _____

7. The training described in Paragraph 6 is recognized by Iowa Vocational Rehabilitation Services (IVRS).

8. Claimant is receiving services from IVRS.

   a. Signature of IVRS Counselor: _____

   b. Date of Signature: _____

   c. Name of IVRS Counselor: _____

   d. IVRS Office Address: _____

12. Claimant: ☐ Waives an evidentiary hearing under Iowa Code section 17A.12.

   ☐ Requests an evidentiary hearing.

_____

Signature of Claimant's Attorney – *or* – Self-Represented Claimant

Full Name: _____

Law Firm: _____

Telephone: _____

Email: _____

Mailing Address: _____

_____

_____

PROOF OF SERVICE

I, _____, hereby swear or affirm under Iowa law and the penalty of perjury that, in accordance with Iowa Code section 85.39(2), on the date of _____, I served a copy of the foregoing instrument:

☐ By certified mail, returned receipt requested, on the employer at the address provided in Paragraph 1.

☐ Other: _____

_____ _____

Signature Date