

REPORT ON REHABILITATION

Michigan Department of Consumer & Industry Services
Bureau of Workers' & Unemployment Compensation
PO Box 30016, Lansing, MI 48909

INSTRUCTIONS: Reports are due 3 months from date of injury and every 4 months thereafter. **All reports to be accompanied by a current medical report.** For further details refer to R 408.45(1) of the Workers' Disability Compensation Act and Rules of Practice.

Part A.

| | |
|--|--------------------------|
| Employee | Social Security # |
| Employer | Date of Injury |
| Insurance Carrier or Service Co. if Self-Insured | NAIC or Self-Insurance # |

Part B. If applicable, complete and proceed to Part E

| | | | |
|---|-------|-----|------|
| 1. Employee returned to work on (If a final Form BWC-701 has been submitted, filing of this form is not required.) | Month | Day | Year |
| 2. Employee is expected to return to work on | | | |

Part C. Complete if Part B above does not apply

| | | | |
|---|----------------------|-----|------|
| 3. Employee is unlikely to be able to return to work. If so, further action is required. Indicate type of action to be taken and target date of such action. Please be specific. (i.e., consultative medical examination, vocational rehabilitation evaluation, etc.) | Target Date Month | Day | Year |
|---|----------------------|-----|------|

Part D. If a vocational rehabilitation referral has been made, please complete the following:

| | | | |
|----------------------------|--------------|-------|----------|
| Facility/Individual's Name | Provider ID# | | |
| Street or PO Box | City | State | ZIP Code |

Part E.

Comments:

Control Disability Costs—Invest in Early Rehabilitation

| | |
|---|-----------------------------------|
| Claims person to whom correspondence should be sent | Telephone No. (Include area code) |
| Claims office address (If different than carrier above) | |
| Authorized Signature | Date of Report |

Form #

BWC-110

Form Name:

Report on Rehabilitation

Instructions:

Completing the Form:

- ✓ Select the hand tool from the Acrobat toolbar menu. You can use the hand tool to move the page around so that you can view all areas.
- ✓ Position the hand pointer inside a form field and click. The I-beam pointer allows you to type text.
- ✓ To complete the "red boxes," using your mouse, position the cursor over the applicable box until the pointing finger icon appears and click.
- ✓ Press Tab to accept the field change and go to the next field, or Press Shift + Tab to accept the field change and go to the previous field.
- ✓ Use your mouse to select an area of the form that is not inside a form field before printing your form.
- ✓ To print, be sure to use the printer button on the Acrobat toolbar menu to print the form instead of your web browser's print function. You may need to select the "Print as image" option in the print dialog box to print the completed form.
- ✓ To print the completed form only, select "Print Current Page" or "Pages From: 1 To: 1"

NOTE: Please complete all date fields with the **MM/DD/YYYY** format.

If you have any comments on this fill-inform, please send them to bwdcinfo@cis.state.mi.us. Please include the keyword "Fill-In Form 110" with your comments.

**How to Submit
This Form:**

- ✓ Print the completed form
- ✓ Keep a copy for your records
- ✓ Mail the original signed Form 110 along with a current medical report to:

**Bureau of Workers' Disability Compensation
P O Box 30016
Lansing MI 48909**