Rehabilitation Request

State of Connecticut
Department of Aging and Disability Services
Rehabilitation Services
21 Oak Street, 4th Floor
Hartford, CT 06106-8011

Please TYPE or PRINT IN INK

Rev. 5-1-2024

WCR-1

Date filed ith Rehabilitation Services

for internal use only

This form may be submitted in-person, mailed to the address above, faxed to 959-200-4789 or emailed to WCC.Forms@ct.gov.

Name	**Date of Birth (Required)**	**Injured Body Part**

Address Number Street City or Town State Zip Code

Date of Injury	**City or Town Where Injured**	**Employer Name at Time of Injury**

Applicant Email Address *(Optional)*	**Telephone** *(Area Code + Number)*

I wish to Receive Services That Will Help Me Return to Work *EMPLOYEE SIGNATURE REQUIRED*	**Date**

FOR OFFICE USE ONLY

Rehabilitation District	**Compensation District**	**WCC File #**	**Comments**

Referral Source

Address	**Date**