



Rehabilitation Request

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

Rev. 5-1-2024

WCR-1

Date filed with Rehabilitation Services

Please TYPE or PRINT IN INK

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

for internal use only

Name	Date of Birth <i>(required)</i>	Injured Body Part
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Address	<i>(Number and Street)</i>	<i>City or Town</i>	<i>State</i>	<i>Zip Code</i>
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Date of Injury	City or Town Where Injured	Employer at Time of Injury
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Applicant Email Address <i>(Optional)</i>	Telephone <i>(Area Code + Number)</i>
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I wish to receive services that will help me to return to work — <i>EMPLOYEE SIGNATURE REQUIRED:</i>	Date
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FOR OFFICE USE ONLY

Rehabilitation District	Compensation District	WCC File #	Comments
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Referral Source

Address	Date
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