ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Division of Workers' Compensation, Reemployment Benefits Section
3301 Eagle Street, Suite 301, Anchorage AK 99503-4149

ELIGIBILITY EVALUATION CHECKLIST

AWCB Case Number:

INSTRUCTIONS: This form is designed to assist the assigned rehabilitation specialist (RS) in completing the eligibility evaluation report. Information that is included in this form is also used in the Reemployment Benefits Administrator's annual report.

1. Employee's Name (Last, First, Middle Initial)		**2. Date of Injury**
3. Address		**4. Social Security Number**
City State Zip Code	**5. Telephone**	**6. Date of Birth**
7. Employer	**8. Insurer/Adjusting Company**	
9. Address	**10. Address**	
City State Zip Code Telephone	**City State Zip Code Telephone**	

THE FOLLOWING MAY BE ATTACHED OR COVERED IN THE EVALUATION REPORT:

11. ☐ Employee's description of job at the time of injury.
12. ☐ Employee's description of jobs held and/or for which training was received. (Since ten years prior to injury.)
13. ☐ Employer's description of Employee's job at injury (if different from Employee's).
14. ☐ Employer's offer of alternative employment (if alternative employment has been offered).
15. ☐ Whether Employee has been rehabilitated under a prior workers' compensation claim and returned to work in the same or similar occupation in terms of physical demands.
16. ☐ Whether Employee previously declined a plan, received job dislocation benefits and returned to work in the same or similar occupation in terms of physical demands.
17. ☐ State of Alaska classified employee has been advised of his/her rights and responsibilities under AS.39.25.158. (This is only applicable if you have been assigned a case in which a State of Alaska employee is the injured worker).
18. ☐ Selection of appropriate job descriptions from U.S. DOL 1991 Revised DOT and 1993 SCODRDOT and submission to physician for review.
19. ☐ Physician's review and comments on appropriate SCODRDOT job descriptions.
20. ☐ Documentation of physician's prediction that a permanent partial impairment rating greater than zero percent is anticipated, or was given, at the time of medical stability.

THE FOLLOWING INFORMATION IS NEEDED FOR THE ADMINISTRATOR'S ANNUAL REPORT PER AS 23.30.041(b):

21. Eligibility evaluation cost billed to Employer $ _____ at the following rate per hour $ _____

(Please attached a copy of your billing statement.)

22. **PROOF OF SERVICE:** I certify that on the date in #26 below, I mailed a copy of the Eligibility Evaluation Checklist form, eligibility evaluation report, and all attachments, to the following:

- ☐ **a.** Employee
- ☐ **b.** Insurer
- ☐ **c.** The Reemployment Benefits Administrator at the address in the header
- ☐ **d.** Attorney for Insurer (if represented)
- ☐ **e.** Attorney for Employee (if represented)
- ☐ **f.** Other (state name and address below)

NAME: _____

ADDRESS: _____

23. Name of Rehabilitation Specialist	**24. Signature**
25. Rehabilitation Specialist's Address	
City State Zip Code Telephone	**24. Date Mailed**