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State of California
Division of Workers' Compensation
Rehabilitation Unit

NOTICE OF TERMINATION OF VOCATIONAL REHABILITATION SERVICES

SSN (Numbers Only)

Case Number

Date of Birth: MM/DD/YYYY

Claim Number

☐ a specific injury on _____ MM/DD/YYYY

☐ a cumulative trauma injury which began on _____ (START DATE: MM/DD/YYYY) and ended on _____ (END DATE: MM/DD/YYYY)

Employee (All information in this section must be completed)

First Name

MI

Last Name

Street Address /PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Employee Representative (All information in this section must be completed)

First Name

MI

Last Name

Firm Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Phone

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Claims Mailing Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer (All information in this section must be completed)

Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer Representative (If applicable)

First Name MI

Last Name

Firm Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Phone

Qualified Rehabilitation Representative

First Name _____ MI _____

Last Name _____

Firm Name _____

Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Phone _____

CLOSURE REASONS (Check one box which applies) (All information in this section must be completed)

- ☐ 1. The employee declines and has signed the RU-107 or RU-107A.
- ☐ 2. The qualified employee completes a vocational rehabilitation plan.
- ☐ 3. The qualified employee unreasonably fails to complete a vocational rehabilitation plan.
- ☐ 4. The employee has not requested vocational rehabilitation within 90 days.
- ☐ 5. The employer offers and the employee accepts/rejects modified work lasting 12 months, even if the employee voluntarily quits prior to the end of the 12 month period. (Attach the RU-94.)
- ☐ 6. The employer offers and the employee accepts/rejects alternative work meeting all of the conditions listed in Labor Code, § 4644(a)(6). (Attach the RU-94.)
- ☐ 7. The employer offers and the employee accepts a job not meeting criteria of #5 or #6. (Attach the RU-94.)

SUMMARY OF SERVICES PROVIDED (All information in this section must be completed)

Number of weeks of VRMA:
(Within the cap) _____

Total Amount of paid VRMA:
(Within the cap) _____

Total Amount of PD supplement: _____

Amount Paid for QRR: _____

☐ Modified Job (Labor Code, § 4644 (a)(5).)

☐ Alternate Job (Labor Code, § 4644 (a)(6).)

☐ "Other Job" (Labor Code, § 4644 (a)(7).)

Did employee RTW? ☐ Yes ☐ No

If Yes, employee's new job title: _____

Wages: $ _____ Per ☐ Hour ☐ Week ☐ Month

(Please Select One)

DOIs on/after 1/1/94 (All information in this section must be completed)

VR initiated before 1/1/98

Phase I: $ _____

Phase II: $ _____

Phase III: $ _____

VR initiated on/after 1/1/94

Phase A: $ _____

Phase B: $ _____

Total Cost of QRR Services: $ _____

QRR Name: _____

Total Cost of Other VR Services: $ _____

Amt. Withheld for Employee's Attorney (if any) $ _____

Plan Completion (All information in this section must be completed)

Plan Type

☐ Direct Placement ☐ OJT ☐ Training

☐ Self Employment ☐ Modified Job ☐ Alternate Job

Employed in Plan Objective: Yes ☐ No ☐

If Yes, employee's new job title: _____

Wages: $ _____ Per ☐ Hours ☐ Week ☐ Month

(Please Select One)

NOTICE TO EMPLOYEE

If you agree with the above, no further action is required on your part, and we will not be providing vocational rehabilitation services in the future. If you disagree with our determination that we have no further liability to provide vocational rehabilitation services, you or your representative must submit your written objections and the reason for them to the Rehabilitation Unit within twenty (20) days of receipt of this Notice, the Request for Dispute Resolution form is used to make your objection known is enclosed. Be sure to send a copy of your objection, if any, to me. The Rehabilitation Unit will then determine if you are to receive further services.

If you have any questions about this notice, you may contact Employer Representative at _____

Phone Number (Numbers Only)

Rehabilitation Unit
California Division of Workers' Compensation

RU-105

NOTICE OF TERMINATION OF REHABILITATION SERVICES

Purpose:
To notify the employee of the employer's termination of liability to provide rehabilitation services. It is not to be used for non-feasibility. This notice is not to be used for injuries prior to 1990.

Submitted by:
Claims Administrator to the injured employee and representative.

When submitted:
Within 10 days of the circumstances set forth in Labor Code §4644(a).

Where submitted:
Original of the notice is sent to the employee and a copy to the applicable Rehabilitation Unit district office. The Rehabilitation Unit's venue is the same as the WCAB. If no WCAB case exists, file with a Rehabilitation Unit within the county where the injured employee resides.

Accompanying documents:
- RU-94 for DOI's on or after 1/1/94 where an offer of modified or alternate work has been accepted or rejected.
- Agreed upon plans for represented injured workers whose date of injury is on or after 1/1/94. (See 1994-1999 rules - AR 10126b(3))
- All declination forms and Notice of Potential Eligibility.
- A copy of proof of service.

Rehabilitation Unit action:
When the employee objects to the notice of termination, the Rehabilitation Unit will hold a conference or otherwise obtain the employee's reason for objection and issue its decision.

Notes: Copies of medical or vocational reports are not required to be submitted to the Rehabilitation Unit when filing a copy of the RU-105 on injuries subsequent to 1/1/90.

All RU-105 Notices must have a "Proof of Service" as required by AR 10131(a). For further information of "Proof of Service". See 8 Cal. Code of Regulation §10514.