FLORIDA DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
SUBROGATION WORKSHEET

Name:
Customer ID:
Address:
City/State/Zip ,
Phone Number: E-Mail:

Counselor/Case Manager: VR Office: Unit

PLEASE NOTE: When the Division of Vocational Rehabilitation (VR) pays for services for an eligible individual, it has the right to **reimbursement** for those services when a financial award is made to the individual from a third party who caused the injury that necessitated those services. When you apply for or receive services from VR, you have given VR the right to payments from that third party for any services provided to you. You have also authorized VR to release information about your services for the purpose of obtaining reimbursement.

****As an applicant for or recipient of any vocational rehabilitation services, you are required by law (Section 413.445, Florida Statutes) to inform VR of any rights you have to third party payments for these services.****

1. Is your disability the result of an accident? ☐ Yes ☐ No
2. What is the date of the accident?_____
3. What is the location where the accident occurred (city and state)?_____
4. Is your disability in any way related to the actions or inaction of another party (individual or company)? ☐ Yes ☐ No
5. If the disability is the result of an accident, was it work-related? ☐ Yes ☐ No
6. If the answer to question 5 is yes, please identify the other party or parties:
   Employer Name:
   Address:
   City/State/Zip: ,
   Phone Number: ( )
7. Have you consulted with or do you plan to consult a lawyer regarding your injury?
   ☐ Yes ☐ No

   Attorney's name:
   Address:
   City/State/Zip: ,
   Phone number: ( ) E-Mail:

8. Do you currently have a lawsuit filed? ☐ Yes ☐ No

   If yes, please provide the case number and county in which the case is filed:

   County: Case No:

9. Provide a description of the accident and the injuries that resulted:

IMPORTANT: Customer must answer ALL applicable questions. If customer does not know the answer at the time of completing this form, he/she must obtain the answer and contact counselor to provide the missing information as soon as possible. **The counselor must follow up with the customer until this form is complete.**

I have read and understand the above: _____

Applicant/customer signature or
guardian/representative signature

Date:

Counselor Comments: