



# FLORIDA DEPARTMENT OF EDUCATION DIVISION OF VOCATIONAL REHABILITATION SUBROGATION WORK SHEET

Name: \_\_\_\_\_  
 Customer ID: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Counselor/Case Manager:

Suncom/Phone #:

Area: Address:

City/State/Zip:

Supervisor:

E-Mail:

1. Is your disability the result of an accident?  Yes  No
2. What is the date of the accident? \_\_\_\_\_
3. If the disability is the result of an accident, was it work-related?  Yes  No
4. Is your disability in any way related to the actions or inaction of another (third) party (individual or company)?  Yes  No
5. If the answer to question 4 is yes, please identify the other party or parties:  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone Number: (    ) \_\_\_\_\_
6. 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: \_\_\_\_\_
7. Comments:

**PLEASE NOTE:**

When the Division of Vocational Rehabilitation (DVR) 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. When you apply for or receive services from the Division of Vocational Rehabilitation, you have given DVR the right to payments from that third party for any services provided to you. You have also authorized DVR to release information about your services for the purpose of obtaining reimbursement.

As an applicant or recipient of any Vocational Rehabilitation services, you are required by law (Florida Statute 413.445) to inform VRS of any rights you have to third party payments for these services.

**I have read and understand the above:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Applicant/client signature or guardian/representative

Counselor Comments: