NEW YORK STATE | Workers' Compensation Board

Loss of Wage Earning Capacity Vocational Data Form

State of New York - Workers' Compensation Board

VDF-1

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Before completing this form, you may wish to speak to a legal representative. You can also call 1-800-580-6665, and ask to speak with the Board's Advocate for Injured Workers. Please answer all questions completely. Attach extra pages if needed.

A. Your Information

Name: _____ WCB Case # (if known): _____
First Last MI

Address: _____
Number and Street City State Zip Code

Date of Birth: _____ Social Security #: _____ Date of Injury/Disablement: _____

B. Your Education (select highest level of education)

☐ Less than High School ☐ High School Diploma or GED ☐ Some College ☐ College Graduate

In what Country did you achieve your highest level of education: ☐ United States ☐ Other (please specify) _____

Have you received any specialized work training or had an apprenticeship? ☐ Yes ☐ No

If Yes, please list type of training: _____

Date Completed: _____ Certification/License received: _____

Expiration date(s) of Certification/License: _____

Have you served in the US military? ☐ Yes ☐ No Branch: _____ Dates: _____

Specialized training while in the US military: _____

Please list any additional training. Include the name of the school/program, the date of training and any degree or certificate earned.

_____

_____

C. Your Work Experience

List all job titles during the past 10 years (such as warehouse worker, cook), most current first. Attach additional sheet if necessary.

Job Title: _____

Job Duties: _____

_____

Length of Time in this Job (in years): _____

Job Title: _____

Job Duties: _____

_____

Length of Time in this Job (in years): _____

Job Title: _____

Job Duties: _____

_____

Length of Time in this Job (in years): _____

D. Your Knowledge and Use of the English Language

Select the level of ability to: Speak ☐ Well ☐ Not Well ☐ Not at all
Read ☐ Well ☐ Not Well ☐ Not at all
Write ☐ Well ☐ Not Well ☐ Not at all

The information I am providing is true and accurate to the best of my knowledge and belief. This form is signed under penalty of perjury.

Signature of Claimant: _____

Claimant's Name (please print clearly): _____

Date: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**