Department of Veterans Affairs

REQUEST FOR MEDICAL SERVICES - CHAPTER 31

PART I - *(To be completed by Vocational Rehabilitation Counselor)*

TO	Health Care Provider

INSTRUCTIONS: The claimant named below is a participant under Chapter 31, Title 38, U.S.C. If it is determined he or she needs medical or dental treatment, please provide under appropriate VA Regulations. If the claimant's medical condition requires a leave of absence, reduced work tolerance, or makes training or employment questionable, include this information in Item 14A. After completing the form, if returning the form by mail send to: Veteran Readiness and Employment (VR&E) Intake Center, Department of Veterans Affairs, P.O. Box 5210, Janesville, WI 53547-5210.

1. NAME OF CLAIMANT *(First, middle, last)*	2. VA FILE NUMBER	3. DATE OF BIRTH *(Mo., day, yr.)*

4. ADDRESS OF CLAIMANT	5. TELEPHONE NUMBER *(Include Area Code)*
	CELL - HOME -

6. REHABILITATION GOAL OF CLAIMANT	7. ANTICIPATED DATE OF REHABILITATION

8. DESCRIBE REASONS FOR REFERRAL

9. NAME OF VOCATIONAL REHABILITATION COUNSELOR	10. EMAIL ADDRESS

11. SIGNATURE OF VOCATIONAL REHABILITATION COUNSELOR	12. TELEPHONE NO.	13. DATE

PART II - *(To be completed by Medical Personnel)*

14A. REPORT OF SERVICES PROVIDED AND DISPOSITION OF CASE

14B. CHECK BOX IF APPLICABLE

☐ SEPARATE MEDICAL REPORT WILL FOLLOW

15A. NAME OF TREATING PROVIDER AND TITLE

15B. NAME OF PRACTICE AND ADDRESS (If the Provider is outside the VA)	

16. SIGNATURE OF EXAMINING PHYSICIAN	17. DATE