

Submit to:  
 Department of Consumer & Business Services  
 Workers' Compensation Division  
 350 Winter St. NE  
 P.O. Box 14480  
 Salem, Oregon 97309-0405

# Request for Administrative Approval

Date: \_\_\_\_\_ Worker: \_\_\_\_\_  
 Counselor name: \_\_\_\_\_ WCD file no.: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Insurer: \_\_\_\_\_  
 Vocational rehabilitation organization (name, city): \_\_\_\_\_  
 Claim no.: \_\_\_\_\_  
 DOI: \_\_\_\_\_

**Reason for request (*check one*):**

- Extension of training beyond 16 months; *director's approval required by ORS 656.340(12)***  
 **Other (explain):** \_\_\_\_\_

**Approval requested for:**

1.  Extension of training beyond 16 months due to:
  - a)  Exceptional disability
  - b)  Exceptional loss of earning capacity
2.  Director's Waiver (OAR 436-120-0003(5))
3.  Other:

**Explain what you are requesting and why it is necessary. Attach all medical and vocational reports or other information that supports this request that you have not already submitted to WCD.**

**INSURER APPROVAL:**

\_\_\_\_\_  
*Insurer signature* *Date*

**Phone:** \_\_\_\_\_

**WCD APPROVAL:**

\_\_\_\_\_  
*WCD signature* *Date*

**For WCD use only**

