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: _____

Instructions for Completing Form VDF-1, "Loss of Wage Earning Capacity - Vocational Data Form"

Please answer all questions completely. Attach extra pages if needed. Send this form to the Workers' Compensation Board at the address listed below. 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. The facts on this form will be used to determine your loss of wage earning capacity.

If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Be sure to enter your name and the date of your injury or illness.

Section A - Your Information:

- Enter your full name. Include first name, middle initial, and last name.
- Enter your Workers' Compensation Board Case Number, if known.
- Enter your mailing address. Include P.O. Box, if applicable, city or town, state, and Zip code.
- Enter your Date of Birth.
- Enter your Social Security Number. This is important to help service your claim faster.
- Enter Date of Injury.

Section B - Your Education:

- Check the box next to the highest level of education you achieved.
- Check "Yes" if you have completed any specialized training apprenticeship. Check "No" if you have not. If you answered "Yes", list the type of training and apprenticeship. Provide the date the training or apprenticeship was completed. List any certification or license received and the date it will expire.
- Check "Yes" if you have served in the U.S. military. Check "No" if you have not. If you answer "Yes" to the question, identify the branch of the military in which you served. Fill in the dates of service. List any occupational and/or specialized training you received.
- If you completed any additional training not listed above, please list the type of training you received. Identify any degree or certificate you earned.

Section C - Your Work Experience:

- List your most recent job title (such as warehouse worker, cook). If you had this job with more than one employer, list it just once.
- List your typical job activities and duties.
- State how long you held this job.

Section D - Your Knowledge and Use of the English Language:

- Indicate your knowledge and use of the English language.

Submit signed, original to the Workers' Compensation Board and retain a copy for your records.

***A potential employer cannot require you to release your workers' compensation records. See Workers' Compensation Law Section 110-a*.**

HOW TO FILE THIS FORM

Reports should be filed by sending directly to the Workers' Compensation Board at the address below with a copy to the insurance carrier. Reports may also be filed via facsimile to the Board's statewide fax number, 1-877-533-0337. When attaching additional documents, please include the Board case number (WCB #) on every page.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205