SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION
DIVISION OF LABOR AND MANAGEMENT
Tel: 605.773.3681 dlr.sd.gov

MEMORANDUM OF PAYMENT FOR REHABILITATION

Claim Administrator Information:

Claim Administrator Federal ID No _____ **Carrier Code** _____ **Claim #** _____

Name (DBA) _____

Address _____ **City** _____ **State** _____ **Zip** _____

Telephone Number _____ **Form Completed By** _____

Employer Information:

Employer Federal ID No _____ **Employer Name (DBA)** _____

Employee/Injury Information:

Employee/Claimant SSN _____ **Date of Injury** _____

Body Part(s) Injured _____ _____ _____ _____

Employee/Claimant Name _____ _____ ___
(Last) (First) (MI)

Retraining/Rehabilitation Information:

Claimant's Gross Average Weekly Wage $ _____

Claimant's compensation rate is $ _____

Compensation to be paid for rehabilitation (SDCL 62-4-5.1) is $ _____

The compensation is based on the following information:

The employee is unable to return to his/her usual and customary occupation as of _____

The program of retraining will begin on _____ **and end on** _____

The program of rehabilitation will begin on _____

The program to be undertaken is as follows: (Give a brief description of the program)

If additional medical treatment is required in the future as a result of such injury, the employer/insurer shall be obligated to pay such future medical expenses.

This memorandum is a receipt only. It does not constitute an agreement, stipulation or release. The Division of Labor and Management retains jurisdiction as to all issues. The employee does not waive his/her right to pursue any benefits to which he/she may be entitled.

Claimant/Employee Signature _____ **Date** _____

Claim Administrator Signature _____ **Date** _____

Division of Labor and Management Approval by _____ **Date** _____

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Completed and signed form should be mailed to the insurance company