



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS  
**REPORT OF SERIOUS INJURY REFERRAL FORM**  
**SECOND INJURY FUND**

P.O. Box 58  
Jefferson City, MO 65102-0058  
573-751-4231  
labor.mo.gov/DWC

Please complete this form for an injured worker that you feel may qualify as seriously injured as defined in the Statement of Policy – Eligibility Guidelines for Second Injury Fund rehabilitation benefits.

Complete to the best of your knowledge.

Injured Worker: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Treating Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Person Referring: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date Treatment Began: \_\_\_\_\_ Date Treatment Ended (if completed): \_\_\_\_\_

**Return completed form to:**

**Fax: 573-522-1623**

**Phone: 573-526-3876**

**Mail: Attn: Physical Rehabilitation  
Missouri Division of Workers' Compensation  
P. O. Box 58  
Jefferson City, MO 65102-0058**

*Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711*