



This form must be used to request the transfer of rehabilitation authority for a current serving member from the Chief of the Defence Force (CDF) to the Military Rehabilitation and Compensation Commission (MRCC) and be completed by the member's Defence Rehabilitation Case Manager, a delegate of the CDF. This form is NOT required for a serving member that is medically separating where Rehabilitation Authority is not transferring to DVA prior to the separation date.

The MRCC, after considering this advice from the CDF, may determine in writing that the Commission be the rehabilitation authority **for the specified person for a specified time**. This may occur in limited circumstances where it is in the best interest of the member and complies with [DVA policy](#).

Part A	Member Details
1. Member surname	<input type="text"/>
2. Member given name(s)	<input type="text"/>
3. Address	<input type="text"/> POSTCODE <input type="text"/>
4. Date of birth	<input type="text" value="/ /"/>
5. Defence PMKeys number	<input type="text"/>
6. Service Category (SERCAT) or Service Option (SERVOP)	<input type="checkbox"/> Permanent member (SERCAT 6 or 7) <input type="checkbox"/> Reservist on Continuous Full Time Service (SERVOP C) <input type="checkbox"/> Part Time Reservist (SERCAT 3 - 5) <input type="checkbox"/> Standby Reservist (SERCAT 2)
7. MEC Review Board	<input type="checkbox"/> Applicable <input type="checkbox"/> Not applicable Date <input type="text" value="/ /"/>

Part B	Request for Transfer Details
8. Who has recommended this transfer?	<input type="checkbox"/> Defence representative <input type="checkbox"/> DVA representative <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">           Note: If recommended by DVA, not all the required information may be available to Defence.         </div>
9. Reason(s) why transfer of rehabilitation authority is requested?	<input type="checkbox"/> Whole of person rehabilitation with high level or complex needs that the ADF cannot address <input type="checkbox"/> Issues that mean the ongoing involvement with the ADF is likely to have a detrimental impact on the member's wellbeing and recovery <input type="checkbox"/> A need for aids and appliances that the ADF is unable to provide <input type="checkbox"/> Other - please specify <input type="text"/> <input type="text"/> <input type="text"/>

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**Part B**

**Request for Transfer Details *contd...***

**10. Priority for decision**

Routine (5 - 7 business days)

Urgent (1 - 4 business days) - please provide reason for urgency


**11. Preferred start date for transfer of authority**

/  /
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**12. Length of transfer required**

Up to 3 weeks

4 - 6 weeks

7 - 12 weeks

13 - 40 weeks

Ongoing until separation

Comment (*if applicable*)


**Part C**

**Separation Details**

**13. Is the member separating?**

Yes  ► Proposed State/Territory the member is separating to

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No

**14. Has the separation process started?**

Not started

Started

Separation date confirmed

Separation date (*if applicable*)

/  /
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**15. Conditions leading to separation or request for transfer of Rehabilitation Authority**




Please attach medical evidence that supports the reason for separation and likelihood of an incapacity claim (DM042 and/or MECRB Minutes) if applicable.

Please give reason if medical evidence is not available


**Part D**

**ADF Program Details**

**16. Is the client undertaking an ADF Rehabilitation Program?**

Yes  ▶

 Please attach relevant rehabilitation reports.

No  ▶

Please provide reason


Please give reason if relevant rehabilitation reports are not available


**17. Is the client undertaking vocational activities through the ADF including via the Career Transition Assistance Scheme (CTAS) or Transition for Employment (T4E)?**

Yes  ▶

CTAS  T4E

No

Please provide details


**18. Has the client been referred to the Australian Defence College to seek Recognition of Prior Learning?**

Yes

No

**19. ADF Rehabilitation Manager name**

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**20. ADF Rehabilitation Manager phone number(s)**

[   ]
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Mobile

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**21. ADF Rehabilitation Manager email**

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**22. Current State/Territory where member is undertaking rehabilitation**

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**23. ADF Rehabilitation Provider name**

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**24. ADF Rehabilitation Provider phone number(s)**

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Mobile

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**25. ADF Rehabilitation Provider email**

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<b>Part E</b>	<b>CDF Delegate</b>
26. CDF Delegate name	<input type="text"/>
27. Position	<input type="text"/>
28. Phone number(s)	<input type="text" value="[ ]"/> Mobile <input type="text"/>
29. Email	<input type="text"/>
30. Date of request	<input type="text" value="/ /"/>

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**Once complete, please email this document to [rehabilitation@dva.gov.au](mailto:rehabilitation@dva.gov.au) by clicking on the EMAIL button below for this advice to be considered by a delegate of the MRCC.**