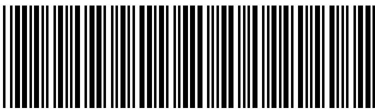
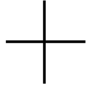
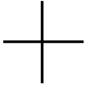


State of California
Division of Workers' Compensation





REQUEST FOR DISPUTE RESOLUTION BEFORE ADMINISTRATIVE DIRECTOR DWC - AD 10133.55

☐ Original ☐ Response

☐ Employer Accepted Claim

☐ Liability found by WCAB

☐ More than 60 Days Since TTD Ended

☐ Has PPD been stipulated, issued/ approved

Claim Number

SSN (Numbers Only)

Case Number

Employee (All information in this section must be completed)

First Name

MI

Last Name

Street Address /PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

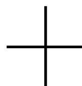
Phone

DOB
MM/DD/YYYY

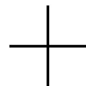
(Choose only one)

a specific injury on
MM/DD/YYYY

a cumulative trauma injury which began on (START DATE: MM/DD/YYYY) and ended on (END DATE: MM/DD/YYYY)



Employee Representative (If Applicable)



Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Phone

Employer (All information in this section must be completed)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Name

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Phone

Employer Representative (if known and If applicable)

Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

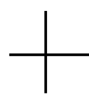
Phone

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

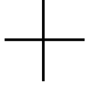
City | State | Zip Code



Vocational & Return to Work Counselor (if applicable)

Name

Firm Name



Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Phone

Administrative Director Requested to resolve the following dispute because the parties disagree on (All information in this section must be completed):

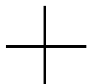
- [ ] Employee's entitlement to a voucher.
- [ ] The parties dispute the amount of the voucher.
- [ ] The insurer has failed to pay training provider.
- [ ] The employee objects to the job offer provided by the employer.
- [ ] Other

Summary of informal efforts to resolve dispute

Requester Name

Signature

Date MM/DD/YYYY



When there is a dispute regarding the Supplemental Job Displacement Benefit, the employee, or claims administrator may request the Administrative Director to resolve the dispute.

- Clearly state the issue(s) and identify supporting information for each issue and position.
- Attach all pertinent documents.
- Serve copies of the request and all attached documents on all parties.
- Mail this Request for Dispute Resolution along with all attached documents to: Administrative Director, Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603.

The opposing party shall have 20 calendar days from the date of the proof of service to submit the original response and all attached documents to the Administrative Director.

The Administrative Director or his or her designee will issue a written determination within 30 calendar days of the date of the opposing party's response. If the Administrative Director requests additional information the written determination will be issued within 30 calendar days from the receipt of the additional information.

In the event no decision is issued within 60 calendar days of the date of the opposing party's response is due or within 60 calendar days of the administrative directors receipt of the requested additional information, whichever is later, the request will be deemed to be denied.

Either party may appeal the determination of the Administrative Director by filing a written petition together with a Declaration of Readiness to Proceed (which can be found at: http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCCAForm10250_1.pdf) within 20 calendar days of the decision or within 20 days after a request is deemed denied. The petition shall set forth the specific factual and/or legal reasons for the appeal.

PROOF OF SERVICE

On ______________________, I served the attached Request for Dispute Resolution on:

☐ by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United States mail.

☐ by personal service.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on: ______________________ at ______________________, CA.

Signature: ______________________

Print Name: ______________________