Supplemental Job Displacement
Nontransferable Training Voucher Form

(Form DWC-AD 10133.57 – Mandatory Form)
For injuries occurring on or after 1/1/04

You have been determined eligible for this nontransferable, Supplemental Job Displacement Voucher. This voucher may be used for the payment of tuition, fees, books, and other expenses required by a state approved or accredited school that you enroll in for the purpose of education related retraining or skill enhancement, or both.

The state approved or accredited school will be reimbursed upon receipt of a documented invoice for tuition, fees, books and other required expenses required by the school for retraining or skill enhancement. If you pay for the eligible expenses, you may be reimbursed for these expenses upon submission of documented receipts. No more than 10 percent of the value of this voucher may be used for vocational or return to work counseling. If you decide to voluntarily withdraw from a program, you may not be entitled to a full refund of the voucher amount utilized.

Please present this original letter to the state approved or accredited school and/or the Vocational & Return to Work Counselor of your choice, chosen from the list developed by the Division of Workers' Compensation's Administrative Director, in order to initiate your training and return to work counseling. A list of Vocational & Return to Work Counselors is available on the Division of Workers' Compensation's website www.dir.ca.gov or upon request. The school and/or counselor should contact me regarding direct payment from your supplemental job displacement benefit.

Injured Employee Information: Upon completing the voucher form the injured employee must return the form with receipts and documentation to the claims administrator immediately for reimbursement. (The claims administrator must complete Nos. 1 – 8 of this voucher form prior to sending it to the injured employee.)

1. Injured Employee Name _____

2. Address _____

   City _____ State _____ Zip Code _____

3. Claim Number _____ Phone Number _____

Claims Administrator

4. Name _____

5. Claims Mailing Address _____

6. City _____ State _____ Zip Code _____

7. Claims Representative _____ Phone Number _____

8. $_____ is available to the injured employee based on _____% of Permanent Partial Disability Award

The injured employee must complete Nos. 9 – 19 and sign and date this voucher form.

(VRTWC) Vocational Return to Work Counselor (if any)

9. Name _____ Phone Number _____

10. Address _____

11. City _____ State _____ Zip Code _____

12. Funds used for vocational and return to work counseling $_____ (10% maximum of voucher value)

Training Provider Details (Attach additional pages for each provider if necessary.)

13. Provider Name _____

14. Provider Address _____ Phone Number _____

15. City _____ State _____ Zip Code _____

16. Provider approval number _____

17. Expiration Date _____

18. Provider Contact Name _____

19. Training Cost _____

Injured Employee Signature _____ **Date** _____

Note to Claims Administrator: Upon receipt of voucher, receipts and documentation from the employee, reimbursement payments to the employee or direct payments to VRTWC and training providers must be made within 45 calendar days.