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State of California
Division of Workers' Compensation
Retraining and Return to Work Unit

Request for Reimbursement of Accommodation Expenses
For injuries on or after July 1, 2004
DWC - AD 10120

Employer (All information in this section must be completed)

Name

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

City State Zip Code

Phone

Employee Information

Employee First Name

Employee Last Name

Claim Number

Job Title (at the time of injury)

Job Duties (attach job description if available):

Date of Birth: 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 of _____ (END DATE: MM/DD/YYYY)

Reimbursement is requested for expenses to accommodate a: (Please Select One)

☐ temporarily disabled employee ($1250 maximum)

☐ permanently disabled employee ($2500 maximum)

Employee's work restrictions and accommodation required (attach treating physician's, QME or AME report, if not previously filed):

Itemized list of costs for which reimbursement is requested (attach all receipts):

1. Modification to work site (list all work done and total cost) Cost

2. Equipment, furniture and/or tools (list each item and cost) Cost

3. Any other accommodation expenses: Cost

(Attach additional sheets if necessary)

Total Costs: _____

The above costs have not been paid for and are not covered by the insurance carrier or any other source.

I declare that the information I have provided on this form is true and correct under penalty of perjury.

_____ Date _____

(Signature of employer or employer's representative) MM/DD/YYYY