



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

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)

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**Employee Representative (If Applicable)**

\_\_\_\_\_  
Name

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

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone

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**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

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**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

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**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 per title 8, California Code of Regulations sections 10133.57 and 10133.58, and/or the VRTWC per title 8 California Code of Regulations sections 10133.57 and 10133.59.

☐

The employee objects to the new job duties provided by the employer.

☐

The employer objects to the amount of reimbursement approved or denied.

☐

Other

Summary of informal efforts to resolve dispute

\_\_\_\_\_  
Requester Name

\_\_\_\_\_  
Signature

Date

\_\_\_\_\_  
MM/DD/YYYY