Reset Form Print Form

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)

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 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