



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 and/or the VRTWC.
- ☐ 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