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

SUPPLEMENTAL JOB DISPLACEMENT NONTRANSFERABLE TRAINING VOUCHER FORM

FOR INJURIES OCCUR**R**ING BETWEEN 1/1/04-12/31/12**, INCLUSIVE**

DWC - AD 10133.57

Injured Employee (To Be Completed By The Employer or Claims Administrator) (All information in this section must be completed)

First Name _____ MI _____

Last Name _____

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

City _____ State _____ Zip Code _____

Claim Number _____ Date of Birth: MM/DD/YYYY _____

Date Voucher Expires _____ MM/DD/YYYY

Phone _____

Claims Administrator (To Be Completed By The Employer or Claims Administrator) (All information in this section must be completed)

Name (Please leave blank spaces between numbers, names or words) _____

Claims Mailing Address (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Claims Representative _____ Phone _____

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

Vocational Return to Work Counselor (if any) (To Be Completed By Employee) (All information in this section must be completed)

First Name _____ MI _____

Last Name _____

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

City _____ State _____ Zip Code _____

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

Training Provider Details (To Be Completed By Employee - Attach additional pages for each provider) (~~**All**~~ **Complete** information in this section ~~**must be completed**~~ **if applicable**) (Institutions must list their names in the first name box)

First Name _____

Last Name _____

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

City _____ State _____ Zip Code _____

Phone _____

Expiration Date _____
MM/DD/YYYY

Provider Approval Number _____

Provider Contact Name _____

Training Cost _____

The Injured Employee Must Sign and Date this Voucher Form

Injured Employee Signature _____

Date _____
MM/DD/YYYY

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.

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 school will be directly reimbursed upon receipt of a documented invoice by the claims administrator of the costs outlined above.

If you pay for the eligible expenses, you may be reimbursed for these expenses upon submission of documented receipts to the claims administrator for immediate reimbursement. If you decide, however, to voluntarily withdraw from a program, you may not be entitled to a full refund of the voucher. If you choose to use the services of a vocational counselor, no more than 10 percent of the voucher may be used for vocational or return to work counseling.

In order to initiate your training or return to work counseling~~,~~ present the voucher to the school or the vocational and return to work counselor of your choice, chosen from the list developed by the Division of Workers' Compensation's Administrative Director.

A list of vocational and 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~~ **the claims administrator** regarding direct payment from your supplemental job displacement benefit.

This supplemental job displacement voucher must be used before the expiration date specified on the first page. After this voucher expires, it will be unusable. All claims for expenses and reimbursement must be submitted to the claims adjuster before the expiration date.

If there is a dispute regarding this voucher, the employee or claims administrator may file Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director" with the Administrative Director, Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603.

If you have a question or need more information, you can contact your employer or the claims administrator. You can also contact a DWC Information and Assistance ("I&A") Officer. Contact information for I&A can be found at: http:w.dir.ca.gov/dwc/ianda.html.