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**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