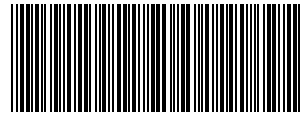


State of California
Division of Workers' Compensation
Retraining and Return to Work Unit



SUPPLEMENTAL JOB DISPLACEMENT
NONTRANSFERABLE TRAINING VOUCHER FORM
FOR INJURIES OCCURRING BETWEEN 1/1/04-12/31/12
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

Phone

Date Voucher Expires

MM/DD/YYYY

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 information in this section must be completed) (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 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.

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