State of California
Division of Workers' Compensation
Rehabilitation Unit
Request for Dispute Resolution

☐ Original ☐ Response

☐ Employer Accepted Claim

☐ Liability found by WCAB

☐ More than 90 Days Since TTD Ended

SSN (Numbers Only) _____ *(DOB: MM/DD/YYYY)* _____ Case No. _____

(Choose only one)

☐ a specific injury on _____ MM/DD/YYYY *Claim Number* _____

☐ a cumulative trauma injury which began on _____ (START DATE: MM/DD/YYYY) and ended on _____ (END DATE: MM/DD/YYYY)

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 _____

Employee Representative

First Name _____ MI _____

Last Name _____

Firm 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

Employer Information

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

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

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

City State Zip Code

Employer Representative

First Name MI

Last Name

Firm Name

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

City State Zip Code

Phone

Qualified Rehabilitation Representative

First Name _____ MI _____

Last Name _____

Firm Name _____

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

City _____ State _____ Zip Code _____

Phone _____

The Rehabilitation Unit is requested to resolve the following dispute on an expedited basis because the parties disagree on : (Check the single issue which applies)

- ☐ The identification of a vocational goal (for injuries after 1/1/94).
- ☐ The selection of a Independent Vocational Evaluator.
- ☐ The description of the employee's job duties at the time of injury (for injuries after 1/1/94).
- ☐ The employee objects to the attached Notice of Intent to Withhold Maintenance Allowance.

Non-Expedited Issues: (Check the issue(s) that apply)

- ☐ The employee objects to a Notice of Termination.
- ☐ The employee's medical eligibility for vocational rehabilitation services. Medical report relied upon by requester

Doctor's Name _____ Date Of Report _____ MM/DD/YYYY

- ☐ The employer has failed to provide vocational rehabilitation services and benefits. My QRR preference is: (if any)

QRR Name _____

On what date should the employer have provided vocational rehabilitation services? _____ MM/DD/YYYY
(Attach explanation)

Date last worked _____ MM/DD/YYYY Date of last temporary disability _____ MM/DD/YYYY

☐ The employee requested reinstatement and the employer failed to respond

On what date was request made to claims administrator?_____ How does the employee substantiate this request? [Attach supporting document(s)]
MM/DD/YYYY

☐ Other disputed issues (please describe the nature):_____

_____

_____

_____

_____

Summary of Parties' Informal Efforts to Resolve this Dispute

An informal conference was held on _____ . A summary of the conference, including a list of attendees, issues addressed, agreements reached and other unresolved issues is attached. If an informal conference was not held, provide an explanation.

_____

_____

_____

_____

_____

_____

Name of Requester: _____

_____ Date: _____
Signature MM/DD/YYYY

Rehabilitation Unit
California Division of Workers' Compensation

Form RU-103

REQUEST FOR DISPUTE RESOLUTION

Purpose:
To request the Rehabilitation Unit to resolve a disputed rehabilitation issue.

Submitted by:
Any party of interest.

When submitted:
The form should only be submitted after all informal methods to resolve the rehabilitation dispute have been exhausted or in response to a RU-103 filed by the other party, or in response to a RU-105 Notice with which the employee disagrees.

Where submitted:
With the applicable Rehabilitation Unit district office. The Rehabilitation Unit's venue is the same as the WCAB's. If no WCAB case exists, file with a Rehabilitation Unit within the county where the injured employee resides.

Form completion:
Your request will be denied if:
- Liability for injury is in dispute.
- The form is incomplete.
- The requester has not attempted to resolve the dispute or such attempts have not been thoroughly documented on the form.
- Copies of all medical and vocational reports not previously filed are not attached.
- Where two or more defendants dispute who has liability for rehabilitation benefits for an injured worker.

Accompanying document:
Attach all medical and vocational reports not previously filed with any units of the DWC or the Appeals Board.

Response to RU-103:
The non filing parties shall have fifteen (15) days to respond by forwarding their position via a RU-103, with supporting information, to the correct Rehabilitation Unit District office with copies to all parties.

Rehabilitation Unit action:
The Rehabilitation Unit shall either issue a determination based on the record, request additional information, or set the matter for formal conference.

Serve all parties.

Please note: An expedited dispute resolution conference is to resolve a single issue as identified on the RU-103. If other issues are raised, a subsequent conference will be scheduled or a determination will be issued on the record.