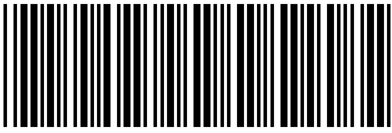
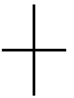


State of California
Division of Workers' Compensation
Retraining and Return to Work Unit



Request for Reimbursement of Accommodation Expenses
For injuries on or after July 1, 2004
DWC - AD 10120

Employer (All information in this section must be completed)

Name

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

City | State | Zip Code

Phone

Employee Information

Employee First Name

Employee Last Name

Claim Number

Job Title (at the time of injury)

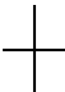
Job Duties (attach job description if available):

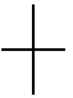
Date of Birth: MM/DD/YYYY

(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)





Reimbursement is requested for expenses to accommodate a: (Please Select One)

☐ temporarily disabled employee ($1250 maximum)

☐ permanently disabled employee ($2500 maximum)

Employee's work restrictions and accommodation required (attach treating physician's, QME or AME report, if not previously filed):

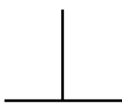
Itemized list of costs for which reimbursement is requested (attach all receipts):

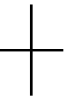
1. Modification to work site (list all work done and total cost)	Cost

2. Equipment, furniture and/or tools (list each item and cost)	Cost

3. Any other accommodation expenses:	Cost

(Attach additional sheets if necessary)





Total Costs: ______________________

The above costs have not been paid for and are not covered by the insurance carrier or any other source.

I declare that the information I have provided on this form is true and correct under penalty of perjury.

______________________________ Date ______________________

(Signature of employer or employer's representative) MM/DD/YYYY