



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

**REQUEST FOR DISPUTE RESOLUTION
BEFORE ADMINISTRATIVE DIRECTOR
DWC - AD 10133.55**

<input type="checkbox"/> Original	<input type="checkbox"/> Response
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- 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 _____ and ended on _____
(START DATE: MM/DD/YYYY) (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

