State of California Division of Workers' Compensation SUPPLEMENTAL JOB DISPLACEMENT NONTRANSFERABLE TRAINING VOUCHER FORM FOR INJURIES OCCURRING BETWEEN 1/1/04-12/31/12, INCLUSIVE 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	n: MM/DD/YYYY
Date Vou	cher Expires	
Phone		MM/DD/YYYY
Claims Administrator (To Be Completed By The Employer or Claims Administrator) (All inf	formation in this se	ction must be completed)
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	formation in this se	ction must be completed)
Name (Please leave blank spaces between numbers, names or words)	formation in this se	ction 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)		

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
Funds used for vocational and return to work counseling \$	(10% max	timum of voucher value)
Training Provider Details (To Be Completed By Employee - Attach additional pages for each section if applicable) (Institutions must list their names in the first name box)	provider) (Co	mplete information in this
First Name		
Last Name		
Address/PO Box (Please leave blank spaces between numbers, names or words)		
· · · ·		
City	State	Zip Code
Phone Expiratio	n Data	
Provider Approval Number		MM/DD/YYYY
Provider Contact Name		
Training Cost		
The Injured Employee Must Sign and Date this Voucher Form		
Injured Employee Signature		_
Date		
Note to Claims Administrator: Upon receipt of voucher, receipts and documentation from	the employe	e,

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 the claims administrator 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.

If there is a dispute regarding this voucher, the employee or claims administrator may file Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director" with the Administrative Director, Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603.

If you have a question or need more information, you can contact your employer or the claims administrator. You can also contact a DWC Information and Assistance ("I&A") Officer. Contact information for I&A can be found at: http://www.dir.ca.gov/dwc/ianda.html.