

Please fill out this form if your current address is not reflected in the SJDB or any other documents. Use this form when your address changes or is differently documented. This form should be filled out by the injured worker and not any other representing party. Please send the completed form to [RTWSP@dir.ca.gov](mailto:RTWSP@dir.ca.gov).

## CLAIMANT INFORMATION

First Name\*

Last Name\*

Claim Number\*

Return to Work Number (Optional) (Example: RTW1234567):

Email\*

Phone Number\*

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## PREVIOUS ADDRESS

Street Name\*

City\*

State\*

ZIP code\*

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## NEW ADDRESS

Street Name\*

City\*

State\*

ZIP code\*

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## EFFECTIVE DATE

Effective Date Of Address Change\*

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## DECLARATION

I declare under penalty of perjury under the laws of State of California that the foregoing is true and correct and that this declaration was executed on the date shown.

Injured Worker's Signature\*

Date\*

*\*DENOTES A REQUIRED FIELD*