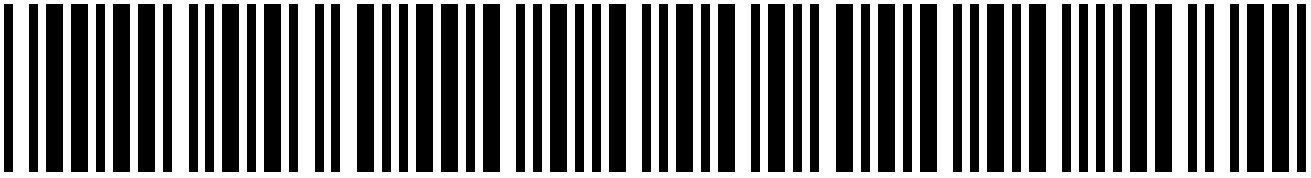
This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET



Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☑

More than 15 Companion Cases ☐

09/10/2008
Date:(MM/DD/YYYY)

SSN: _____

RSU12345
Case Number 1

☐ Specific Injury

☐ Cumulative Injury (Start Date: MM/DD/YYYY) _____ (End Date: MM/DD/YYYY) _____

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

Please check unit to be filed on (check only one box)

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ VOC ☐ INT ☑ RSU

Companion Cases

☐ Specific Injury

_____
Case Number 2

☐ Cumulative Injury (Start Date: MM/DD/YYYY) _____ (End Date: MM/DD/YYYY) _____

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: RSU

Document Type: DWC - AD FORMS

Document Title: DWC-AD 10133.55 REQUEST FOR DISPUTE RESOLUTION BEFORE THE AD

Date of document following Document Separator Sheet

Document Date: _____ MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Author: UNIFORM ASSIGNED NAME

Office Use Only

Received Date: _____ MM/DD/YYYY

DWC-AD 10133.55 **Request for Dispute Resolution Before the Administrative Director** **(For injuries occurring on or after 1/1/04)** ___Original ___Response	Has employer accepted this claim? ___ Yes ___ No Has liability for injury been found by the WCAB? ___ Yes ___ No Has it been more than 60 days since TTD ended? ___ Yes ___ No Has PPD award been stipulated, issued/approved? ___ Yes ___ No	**DWC Use Only**

Social Security Number	**WCAB Number**	**DWC Unit Number**

Employee Name (Last)	(First)	(MI)	Phone	Date of Birth

Address (Street)	(City)	(State)	(Zip)

Employer Name	Phone	**Insurance Company Name; Or, if Self-Insured, Certificate Name**
Address		Adjusting Agency Name (if adjusted)
City, State, Zip		Claims Mailing Address
Date of Injury	**Claim Number**	City, State, Zip Phone No.

Employee Representative (if any)	**Employer Representative**
Firm Name	Firm Name
Address	Address
City, State, Zip Phone No.	City, State, Zip Phone No.

Vocational & Return to Work Counselor (if applicable)

Firm Name Representative Name

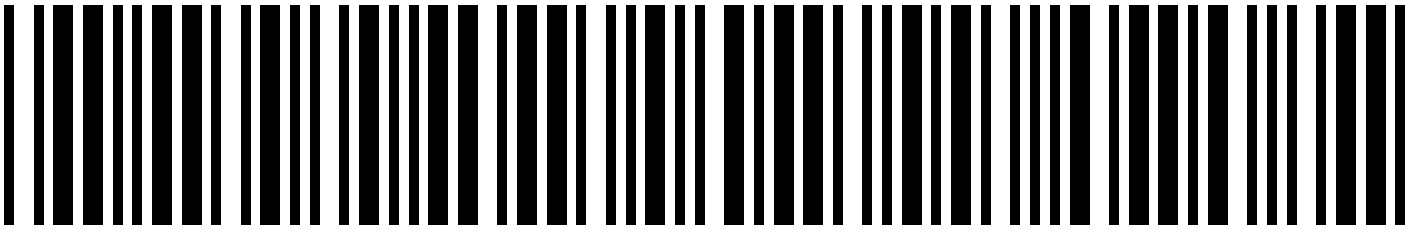
Address (Street, City, State, Zip) Phone No.

The Administrative Director is requested to resolve the following dispute because the parties disagree on: (Please describe and attach all pertinent documents)

Summary of Parties' Informal Efforts to Resolve this Dispute	**Proof of Service: I declare under penalty of perjury under the laws of the State of California that on the date written below, I mailed a copy of this request with a copy of any documents included with this request to the following parties at the following addresses:** **Administrative Director, (SJDB), Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603**
Name of Requester **Date**	**Signature** **Date**

Form DWC-AD 10133.55 (August 18, 2006)

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: RSU

Document Type: SUPPORTING DOCUMENTS

Document Title: POSITION STATEMENT

Document Date: 02/05/2008
MM/DD/YYYY

Author: UNIFORM ASSIGNED NAME

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Office Use Only

Received Date
MM/DD/YYYY

DWC-CA form 10232.2

Statement Dated February 5, 2008

Position Statement authored by
Claims Administrator,
Hearing Representative or
an Unrepresented Injured Worker.

DOCUMENT SEPARATOR SHEET

Product Delivery Unit RSU

Document Type DWC - AD FORMS

Document Title DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR:

Employer (name of firm)_____ is offering you the position of a

(name of job) _____.

You may contact _____ concerning this offer. Phone No.: _____

Date of offer: _____ Date job starts: _____.

Claims Administrator:_____Claim Number:_____

NOTICE TO EMPLOYEE Name of employee: _____

Date of Injury:_____Date offer received: _____

You have 30 calendar days from receipt to accept or reject the attached offer of modified or alternative work. Regardless of whether you accept or reject this offer, the remainder of your permanent disability payments may be decreased by 15%. However, if you fail to respond in 30 days or reject this job offer, you will not be entitled to the supplemental job displacement benefit unless:

Modified Work ☐ or Alternative Work ☐

A. You cannot perform the essential functions of the job; or
B. The job is not a regular position lasting at least 12 months; or
C. Wages and compensation offered are less than 85% paid at the time of injury; or
D. The job is beyond a reasonable commuting distance from residence at time of injury.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

_ I accept this offer of Modified or Alternative work.

__ I reject this offer of Modified or Alternative work and understand that I am not entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I may not be entitled to the Supplemental Job Displacement Benefit.

_____ Date _____

Signature

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is <u>not</u> accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the employee.

The employer or claims administrator must forward a completed copy of this agreement to the Administrative Director within 30 days of acceptance or rejection. (A.D., "SJDB," Division of Workers' Compensation, P.O. Box 420603, S.F., CA 94142-0603)
If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director.

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

POSITION REQUIREMENTS

Actual job title:

Wages: $ per Hour Week Month

Is salary of modified/alternative work the same as pre-injury job? Yes ___ No ___

Is salary of modified/alternative work at least 85% of pre-injury job? Yes ___ No ___

Will job last at least 12 months? Yes ___ No ___

Is the job a regular position required by the employer's business? Yes ___ No ___

Work location: _____

Duties required of the position:

Description of activities to be performed (if not stated in job description):

Physical requirements for performing work activities (include modifications to usual and customary job):

Name of doctor who approved job restrictions (optional):_____ Date of report:_____

Date of last payment of Temporary Total Disability:

Preparer's Name:

Preparer's Signature: Date

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04

Proof of Service By Mail

I am a citizen of the United States and a resident of the County of _____. I am over the age of eighteen years and not a party to the within matter.

My business address is:

_____

On _____, I served the **Notice of Offer of Modified or Alternative Work** on the parties listed below by placing a true copy thereof enclosed in a sealed envelope with postage fully prepaid, and thereafter deposited in the U. S. Mail at the place so addressed.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at _____ on _____.

Signature: _____

Copies Served On: _____

DOCUMENT SEPARATOR SHEET

Product Delivery Unit RSU

Document Type NON-FORM CORRESPONDENCE

Document Title LETTER

Document Date _____
MM/DD/YYYY

Date of document following Document Separator Sheet

Author UNIFORM ASSIGNED NAME

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Office Use Only

Received Date _____
MM/DD/YYYY