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Request for Reimbursement of Accommodation Expenses
For injuries on or after July 1, 2004
Form DWC AD 10005

Name of Employer: Address of Employer:

Phone Number: Name of Injured Employee:

WCAB number (if applicable): Claim Number

Job Title (at time of injury):

Job Duties (attach job description if available):

Date of Injury:

Reimbursement is requested for expenses to accommodate a:

☐ 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):

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

1. Modification to worksite (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.

Signature of employer or employer's representative Date