SAVE PRINT CLEAR

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 94102-3660
Name of Requester Date	Signature Date

(Mandatory Form DWC-AD 10133.55 08/05)