## STATE OF CALIFORNIA **DISABILITY ACCESS COMPLAINT/GRIEVANCE FORM**DIVISION OF WORKERS' COMPENSATION DIR DWC Form 9008 (Effective 2027)

## DEPARTMENT OF INDUSTRIAL RELATIONS DIVISION OF WORKERS' COMPENSATION

Your Information							
Name:							
Address:							
City:	State:	Zipcode:					
Telephone Number:	Email Address:						
Preferred Method of Communication: Telephone	711 Relay	Service	Email		U.S. Mail		
Type of Accessibility Issue:							
Architectural Access - Barriers related to buildi counter heights, and similar issues.	ngs and structures, inc	luding wheeld	chair ramps,	accessible b	athrooms,		
Program Access - Difficulty accessing DWC ber modifications to policies, practices, or procedure		ns, or activities	s, including th	ne need for r	easonable		
Communication Access - Issues related to equal interpreters, or other auxiliary aids and services.		ation, such as	alternative f	formats, sigr	ı language		
Incident Details							
Which office?		DWC C	ase#				
Location of the Issue:	Date of most recent occurrence:						
Describe the problem you encountered: (Please prov	ide as much detail as po	ossible.)					
Would a change in policy or procedure help resolve to	his issue? (If yes, pleas	e describe the	e change you	ı suggest.)			
Staff Involvement							
Name of Staff:	Po	osition:					
Name of Staff:	P	osition:					
Were there others present?							
Name:	P!	hone Number	<del>.</del>				
Name:	P	hone Number	<del>.</del>				

Your Information				
Name:				
Address:				
City:	State:	Zipcode:		
Telephone Number:	Ema	il Address:		
Preferred Method of Communication: Telepl	none 71	1 Relay Service	Email	U.S. Ma
Type of Accessibility Issue:				
Architectural Access - Barriers related to counter heights, and similar issues.	ouildings and structi	ures, including wheeld	chair ramps, accessibl	e bathrooms
Program Access - Difficulty accessing DW0 modifications to policies, practices, or process.		programs, or activities	s, including the need fo	or reasonable
Communication Access - Issues related to interpreters, or other auxiliary aids and serv		mmunication, such as	alternative formats, s	ign language
Staff Involvement				
Name of Staff:		Position:		
Name of Staff:		Position:		
Name of Staff:		Position:		
Name of Staff:		Position:		
Were there others present?				
Name		Phone Number:		
Name:		Phone Number:		
Name:		Phone Number:		
Name:		Phone Number:		

## **Incident Details**

Which office service does this issue involve?	
TYTHEN CHIEC COLVING GOOD WING ISCAR HIVOIVE.	
Location of the Issue:  Date of most recent occurrence:	
Describe the problem you encountered: (Please provide as much detail as possible.)	
Would a change in policy or procedure help resolve this issue? (If yes, please describe the change you suggest	.,