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 94142-0603
Name of Requester Date	Signature Date

Form DWC-AD 10133.55 (August 18, 2006)