AUDIT COMPLAINT FORM

IF YOU WANT THIS COMPLAINT TO BE KEPT CONFIDENTIAL, PLEASE MARK THIS BOX: ☐

DIR PRIVACY NOTICE: The Department of Industrial Relations, Division of Workers' Compensation uses the information in your complaint (1) to monitor workers' compensation claims administrators; (2) to assist DWC and other government agencies in general civil and criminal law enforcement; and (3) to conduct research on the workers' compensation system. **If you indicate that you want your complaint kept confidential, the Audit Unit will not share your complaint with any party named in your complaint.** If you do not request confidentiality, the Audit Unit may share your complaint with the claims administrator. Please note that your complaint and your workers' compensation claim information cannot be disclosed to the public under the Public Records Act. If you have questions about this notice please write to Privacy@dir.ca.gov.

Claims administrator / Company name	Injured worker name
Claims administrator's address	Claim number
City, state, zip **(physical location only- do not use P.O. Box)**	Date of injury
Date or period of violations	Employer

SPECIFIC DETAILS OF COMPLAINT

Describe the nature of the complaint, being as specific as possible. For example, late payments of temporary or permanent disability (the number of late payments, if known), failure to pay temporary or permanent disability, or 10% self- imposed penalties for late payments (indicate the periods not paid, if known), failure to pay or object to medical treatment or medical-legal bills, failure to investigate a claim, unsupported denial of liability for a claim, et al. Please attach copies of supporting documentation, if available.

Complainant (name & title) _____ Date _____

Address, city, state, zip code _____ Email: _____