Request for Dispute Resolution Has liability for highly bean towing by the WCAB? Before the Administrative Director Has Rebain more than 60 days since TD ended?	DWC-AD 10133.55		Has employer acc		DWC Use Only	
Before the Administrative Director (For injuries occurring on or after 1/1/04)			Yes as liability for injury bee	No en found by the WCAB?		
(For injuries occurring on or after 1/1/04)			YesNo			
(For injuries occurring on or after						
Original Response Social Security Number WCAB Number DWC Unit Number Employee Name (Last) (First) (MI) Phone Date of Birth Address (Street) (City) (State) (Zip) Employee Name Phone Insurance Company Name; Or, If Self-Insured, Certificate Name Address Adjusting Agency Name (If adjusted) City, State, Zip Phone No. Employee Representative (If any) Employee Representative Employee Representative Firm Name Address Address Address City, State, Zip Phone No. Firm Name Firm Name Firm Name Address Address Address Oily, State, Zip Phone No. City, State, Zip Phone No. Firm Name Vocational & Return to Work Counselor (If applicable) Representative Name Address (Street, City, State, Zip Phone No. Firm Name Summary of Parties' Informal Efforts 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: 1 doclare under penalty of	(For injuries occurring on or after Has PPD awar			ulated, issued/approved?		
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City, State, Zip Claim Number Claims Mailing Address Date of Injury Claim Number City, State, Zip Phone No. Employee Representative (if any) Employee Representative Employee Representative Firm Name Firm Name Address Address Address City, State, Zip Phone No. City, State, Zip Phone No. City, State, Zip Phone No. Firm Name Vocational & Return to Work Counselor (if applicable) Representative Name Address (Street, City, State, Zip Phone No. 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 . 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	Employer Name Phone			Insurance Company Name; Or, if Self-Insured, Certificate Name		
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