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)