



Request for Dispute Resolution

<input type="checkbox"/> Original	<input type="checkbox"/> Response
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- Employer Accepted Claim
- Liability found by WCAB
- More than 90 Days Since TTD Ended

SSN (Numbers Only) _____	*(DOB: MM/DD/YYYY) _____	Case No. _____
(Choose only one)		
<input type="checkbox"/> a specific injury on _____ MM/DD/YYYY		Claim Number _____
<input type="checkbox"/> a cumulative trauma injury which began on _____ and ended on _____ (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)		

Employee (All information in this section must be completed)

First Name _____	MI _____
Last Name _____	
Address/PO Box (Please leave blank spaces between numbers, names or words) _____	
City _____	State _____ Zip Code _____

Employee Representative (All information in this section must be completed)

First Name _____	MI _____
Last Name _____	
Firm Name _____	
Address/PO Box (Please leave blank spaces between numbers, names or words) _____	
City _____	State _____ Zip Code _____
Phone _____	

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Employer Information (All information in this section must be completed)

Insured

Self-Insured

Legally Uninsured

Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Employer Representative

First Name

MI

Last Name

Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Phone

Qualified Rehabilitation Representative (All information in this section must be completed)

First Name _____

MI

Last Name _____

Firm Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____

State _____

Zip Code _____

Phone _____

The Rehabilitation Unit is requested to resolve the following dispute on an expedited basis because the parties disagree on : (Check the single issue which applies. (All information in this section must be completed))

- The identification of a vocational goal (for injuries after 1/1/94).
- The selection of a Independent Vocational Evaluator.
- The description of the employee's job duties at the time of injury (for injuries after 1/1/94).
- The employee objects to the attached Notice of Intent to Withhold Maintenance Allowance.

Non-Expedited Issues: (Check the issue(s) that apply)

- The employee objects to a Notice of Termination.
- The employee's medical eligibility for vocational rehabilitation services. Medical report relied upon by requester

Doctor's Name

Date Of Report _____

MM/DD/YYYY

- The employer has failed to provide vocational rehabilitation services and benefits. My QRR preference is: (if any)

QRR Name

On what date should the employer have provided vocational rehabilitation services?
(Attach explanation)

MM/DD/YYYY

Date last worked _____

MM/DD/YYYY

Date of last temporary disability _____

MM/DD/YYYY

The employee requested reinstatement and the employer failed to respond.

On what date was request made to claims administrator? _____ How does the employee
substantiate this request? [Attach supporting document(s)]
MM/DD/YYYY

Other disputed issues (please describe the nature): _____

Summary of Parties' Informal Efforts to Resolve this Dispute

An informal conference was held on _____. A summary of the conference, including a list of attendees, issues addressed, agreements reached and other unresolved issues is attached. If an informal conference was not held, please explain.

Name of Requester: _____

Signature

Date: _____
MM/DD/YYYY

**Rehabilitation Unit
California Division of Workers' Compensation**

Form RU-103

REQUEST FOR DISPUTE RESOLUTION

Purpose:

To request the Rehabilitation Unit to resolve a disputed rehabilitation issue.

Submitted by:

Any party of interest.

When submitted:

The form should only be submitted after all informal methods to resolve the rehabilitation dispute have been exhausted or in response to a RU-103 filed by the other party, or in response to a RU-105 Notice with which the employee disagrees.

Where submitted:

With the applicable Rehabilitation Unit district office. The Rehabilitation Unit's venue is the same as the WCAB's. If no WCAB case exists, file with a Rehabilitation Unit within the county where the injured employee resides.

Form completion:

Your request will be denied if:

- . Liability for injury is in dispute.
- . The form is incomplete.
- . The requester has not attempted to resolve the dispute or such attempts have not been thoroughly documented on the form.
- . Copies of all medical and vocational reports not previously filed are not attached.
- . Where two or more defendants dispute who has liability for rehabilitation benefits for an injured worker .

Accompanying document:

Attach all medical and vocational reports not previously filed with any units of the DWC or the Appeals Board.

Response to RU-103:

The non filing parties shall have fifteen (15) days to respond by forwarding their position via a RU-103, with supporting information, to the correct Rehabilitation Unit District office with copies to all parties.

Rehabilitation Unit action:

The Rehabilitation Unit shall either issue a determination based on the record, request additional information, or set the matter for formal conference.

Serve all parties.

Please note: An expedited dispute resolution conference is to resolve a single issue as identified on the RU-103. If other issues are raised, a subsequent conference will be scheduled or a determination will be issued on the record.