

SUPPLEMENTAL JOB DISPLACEMENT NON-TRANSFERABLE VOUCHER FORM FOR INJURIES OCCURRING ON OR AFTER 1/1/13

This is a supplemental job displacement non-transferrable \$6,000 voucher for education-related retraining and/or skill enhancement. It can be used for education, counseling and/or training services. You can take this voucher to a California public school or to a state-certified provider on the Eligible Training Provider List, at <http://etpl.edd.ca.gov> and the school will be directly reimbursed upon receipt of a documented invoice by the claims examiner. You can also present this voucher to a counselor, which can be selected from the list on the Division of Workers' Compensation's ("DWC") website at: http://www.dir.ca.gov/dwc/SJDB/VRTWC_list.pdf.

This voucher may be applied to any of the following expenses at the choice of the injured employee:

- (1) Education-related retraining or skill enhancement, or both, at a California public school or with a provider that is certified and on the Eligible Training Provider List, including payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement.
- (2) Occupational licensing or professional certification fees, related examination fees, and examination preparation course fees.
- (3) The services of licensed placement agencies, vocational or return-to-work counseling, and résumé preparation, all up to a combined limit of \$600.
- (4) Tools required by a training or educational program in which the employee is enrolled.
- (5) Computer equipment including, monitors, software, networking devices, keyboards, mouse, printers, and tablet computers of up to \$1,000 submitted with appropriate documentation (page 4 of this packet). The employer may give the employee the option to obtain computer equipment directly from the employer. The employee shall not be entitled to reimbursement for games or any entertainment media.
- (6) Up to \$500 as a miscellaneous expense reimbursement or advance, payable upon request (by submitting page 3 of this packet via email or regular mail) without need for itemized documentation or accounting. The employee is not entitled to any other voucher payment for transportation, travel expenses, telephone or internet access, clothing or uniforms, or incidental expenses.

Because you have received this Voucher and are unable to return to your usual employment, you may be eligible for a Return-to-Work Supplement. You must apply within one year from the date this Voucher was served on you. You should make a copy of the Voucher which you will need to apply for the Return-to-Work Supplement. Details about the Return-to-Work supplement program are available from the Department of Industrial Relations on its website, www.dir.ca.gov, or by calling 510-286-0787.

If you pay for eligible expenses, you may be reimbursed for these expenses upon submission of documented receipts to the claims administrator for reimbursement. Reimbursement payments must be made by the claims administrator within 45 calendar days upon receipt of voucher, receipts, and documentation.

If you decide to voluntarily withdraw from a program, you may not be entitled to a full refund of the voucher.

If there is a dispute regarding this voucher, the employee or claims administrator may file Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director" with the Administrative Director, Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603.

If you have a question or need more information, you can contact your employer or the claims administrator. You can also contact a DWC Information and Assistance ("I&A") Officer. Contact information for I&A can be found at: <http://www.dir.ca.gov/dwc/ianda.html>.

This section is to be completed by the Claims Administrator

| | | | |
|------------------------|---------------------------------|----------------|-----------|
| Employee Last Name | Employee First Name | MI | |
| _____ | _____ | _____ | |
| Claims Administrator | Claims Representative | | |
| _____ | _____ | | |
| Claims Mailing Address | | | |
| _____ | | | |
| City | State | Zip Code | Claim No. |
| _____ | _____ | _____ | _____ |
| Claims Phone Number | Claims Email Address (optional) | Date of Injury | |
| _____ | _____ | _____ | |

After this voucher expires, it will be unusable. All claims for expenses and reimbursement must be submitted to the claims adjuster before the expiration date.

Date Voucher Expires: _____
MM/DD/YYYY

Vocational Return-to-Work Counselor (if any) (To Be Completed By the Employee)

If you will be using the services of a vocational return-to-work counselor, and/or training provider/school, please complete the bottom of this page and mail it to the claims administrator.

| | | |
|-----------|---|----------|
| Last Name | First name | MI |
| _____ | _____ | _____ |
| Address: | | |
| _____ | | |
| City: | State | Zip Code |
| _____ | _____ | _____ |
| Phone | Funds used for counseling (not to exceed \$600): \$ | |
| _____ | _____ | |

Training Provider or School Details (if any) (To Be Completed By the Employee)

| | | |
|---------------|-------------------|----------|
| Provider Name | | |
| _____ | | |
| Address: | | |
| _____ | | |
| City: | State | Zip Code |
| _____ | _____ | _____ |
| Phone | Training Cost: \$ | |
| _____ | _____ | |

The Injured Employee Must Sign and Date this Voucher Form

| | |
|------------------|------------|
| Signature: _____ | Date _____ |
| | MM/DD/YYYY |

REQUEST FOR MISCELLANEOUS EXPENSES
SUPPLEMENTAL JOB DISPLACEMENT NON-TRANSFERABLE VOUCHER FORM

This section is to be completed by the Claims Administrator

| | | | |
|------------------------|-----------------------|----------------|-----------|
| Employee Last Name | Employee First Name | MI | |
| <hr/> | | | |
| Claims Administrator | Claims Representative | | |
| <hr/> | | | |
| Claims Mailing Address | | | |
| <hr/> | | | |
| City | State | Zip Code | Claim No. |
| <hr/> | | | <hr/> |
| Claims Email Address | | Date of Injury | |
| <hr/> | | <hr/> | |

I request \$500 as a miscellaneous expense reimbursement or advance.

Injured Employee
Signature: _____ Date _____
MM/DD/YYYY

If you would like to request miscellaneous expenses, please complete this form and submit it to the claims adjuster. If an e-mail address was provided, you can submit this form via e-mail, otherwise, please mail this form to the claims adjuster. You will not be entitled to any other voucher payment for transportation, travel expenses, expenses, telephone or internet access, clothing or uniforms or incidental expenses.

If you are requesting reimbursement for the purchase of computer expenses, please mail a Request for Purchase of Computer Equipment (page 4) to the claims adjuster with appropriate documentation.

If you are requesting reimbursement for the purchase of tuition, fees, books, and/or tools, please mail a Request for Reimbursement of Expenses (page 5) to the claims adjuster with appropriate documentation. Payments must be made by the claims adjuster within 45 calendar days of receipt of the request.

REQUEST FOR PURCHASE OF COMPUTER EQUIPMENT
SUPPLEMENTAL JOB DISPLACEMENT NON-TRANSFERABLE VOUCHER FORM

This section is to be completed by the Claims Administrator

Employee Last Name _____ Employee First Name _____ MI _____

Claims Administrator _____ Claims Representative _____

Claims Mailing Address _____

City _____ State _____ Zip Code _____ Claim No. _____

Claims Phone Number _____ Date of Injury _____

I request a total of \$ _____

- A receipt of purchased equipment is attached for reimbursement.

- A written invoice is attached.

- I accept the claims administrator's/employer's offer to furnish computer equipment. (If an offer was provided.)

Injured Employee Signature: _____ Date _____
MM/DD/YYYY

Up to \$1,000 for purchase(s) of computer equipment including, monitors, software, networking devices, keyboards, mouse, printers, and tablet computers is available. You are not entitled to reimbursement for purchase of games or any entertainment media.

If the computer equipment will be provided directly to you, your employer must provide the computer equipment along with documentation of the cost of the computer equipment within 45 days of receipt of this Request for Purchase of Computer Equipment.

Payment of tuition, fees, books, and tools may also be reimbursed using page 5.

If you have requested \$500 in miscellaneous expenses, you are not entitled to reimbursement for transportation, travel expenses, telephone or internet access, clothing, uniforms, or incidental expenses.

REQUEST FOR REIMBURSEMENT OF EXPENSES
SUPPLEMENTAL JOB DISPLACEMENT NON-TRANSFERABLE VOUCHER FORM

This section is to be completed by the Claims Administrator

Employee Last Name _____ Employee First Name _____ MI _____

Claims Administrator _____ Claims Representative _____

Claims Mailing Address _____

City _____ State _____ Zip Code _____ Claim No. _____

Claims Phone Number _____ Date of Injury _____

I request a total of \$ _____ for reimbursement for expenses. Complete receipts or other documentation must be attached.

Injured Employee
Signature: _____ Date _____
MM/DD/YYYY

If you would like to request reimbursement of expenses for tuition, fees, books, and tools, please complete this page and mail it to the claims adjuster with documentation substantiating your expenses.

If you have requested \$500 in miscellaneous expenses, you are not entitled to reimbursement for transportation, travel expenses, telephone or Internet access, clothing, uniforms, or incidental expenses.

For computer equipment purchases, please complete a Request for Purchase of Computer Equipment (page 4) and mail it to the claims adjuster with appropriate documentation.

PROOF OF SERVICE

On _____, I served the foregoing document(s): Supplemental Job Displacement Non-Transferable Voucher for Injuries Occurring on or After 1/1/13 (Form DWC - AD 10133.32) for Claim Number _____ to the parties listed below:

Name of Injured Worker:

Address:

ADJ Number:

Attorney(s) Name:

Firm Name:

Address:

_____ by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United States mail.

_____ by personal service.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on _____ at _____, CA.

Signature of Person who Served the Papers: _____

Print Name: _____