

<h2 style="margin:0;">Request for Dispute Resolution</h2> <p style="margin:0;">..... Original Response</p>	<p>Has employer accepted this claim? Yes No</p> <p>Has liability for injury been found by the WCAB? Yes No</p> <p>Has more than 90 days of TTD been paid? Yes No</p>	<p>Rehabilitation Use Only</p>	
Social Security Number		WCAB Number	Rehab Unit Number
Employee Name (Last)	(First)	(MI)	Date of Birth
Address (Street)		(City)	(State) (zip)
Employer Name		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		Employer Representative	
Firm Name		Firm Name	
Address		Address	
City, State, Zip	Phone No.	City, State, Zip	Phone No.
Qualified Rehabilitation Representative			
Firm Name		Representative Name	
Address (Street, City, State, Zip)			Phone No.
<p>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)</p> <p> <input type="checkbox"/> The identification of a vocational goal (for injuries after 1/1/94) <input type="checkbox"/> The description of the employee's job duties at the time of injury (for injuries after 1/1/94) <input type="checkbox"/> The selection of a Independent Vocational Evaluator <input type="checkbox"/> The employee objects to the attached Notice of Intent to Withhold Maintenance Allowance </p> <p>Non-Expedited Issues: (Check the issue(s) that apply)</p> <p> <input type="checkbox"/> The employee objects to a Notice of Termination <input type="checkbox"/> The employee's medical eligibility for vocational rehabilitation services. Medical report relied upon by requester: <input type="checkbox"/> The employer has failed to provide vocational rehabilitation services and benefits. My QRR preference is: (if any) _____ </p> <p>On what date should the employer have provided vocational rehabilitation services? ____ / ____ / ____ (Attach explanation)</p> <p>Date last worked ____ / ____ / ____ Date of last temporary disability ____ / ____ / ____</p> <p><input type="checkbox"/> The employee requested reinstatement and the employer failed to respond. On what date was request made to claims administrator? ____ / ____ / ____</p> <p>How does the employee substantiate this request? [Attach supporting document(s)]</p> <p><input type="checkbox"/> This is in response to a previously submitted RU-103 dated ____ / ____ / ____</p> <p><input type="checkbox"/> Other disputed issues (please describe the nature):</p>			
<p style="text-align: center;">Summary of Parties' Informal Efforts to Resolve this Dispute</p> <p>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, attach explanation.</p>		<p>Copies of this request with copies of medical and vocational reports have been served on:</p>	
Name of Requester		Signature	
Date			

**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:

This form will be returned or the request 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.

Accompanying document:

Attach all medical and vocational reports not previously filed.

Response to RU-103:

The other 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.

Copy:

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.