

Request for Reimbursement of Accommodation Expenses
For injuries on or after July 1, 2004
Form DWC AD 10005

Name of Employer: _____ Address of Employer: _____

Phone Number: _____ Name of Injured Employee: _____

WCAB number (if applicable): _____ Claim Number _____

Job Title (at time of injury): _____

Job Duties (attach job description if available): _____

Date of Injury: _____

Reimbursement is requested for expenses to accommodate a:

_____ temporarily disabled employee (\$1250 maximum)

_____ permanently disabled employee (\$2500 maximum)

Employee's work restrictions and accommodation required (attach treating physician's, QME or AME report):

Itemized list of costs for which reimbursement is requested (attach all receipts):

1. Modification to worksite (list all work done and total cost) _____ Cost _____

2. Equipment, furniture and/or tools (list each item and cost) _____ Cost _____

3. Any other accommodation expenses: _____ Cost _____

(Attach additional sheets if necessary)

Total Costs: _____

The above costs have not been paid for and are not covered by the insurance carrier or any other source.

I declare that the information I have provided on this form is true and correct under penalty of perjury.

Signature of employer or employer's representative _____ Date _____