How to file a Petition Appealing Denial of Return-to-Work Supplement Decision

If you do not agree with the decision made by the director over your return-to-work supplement benefit, you must file an appeal.

The petition shall be based upon one or more of the grounds as prescribed for petitions for reconsideration in California Labor Code Section 5903.

Your local district office of the Workers' Compensation Appeals Board (WCAB) must receive your petition within 20 days from the date the director's decision was issued. The date of the decision can be found in the upper left-hand corner of the determination letter.

Your petition must include your full name, ADJ case number, RTWSP application number, and a brief statement of the facts supporting your petition. Please note that all forms must be typed or handwritten in block letters to insure legibility. Fill out the form completely and be sure to sign and date it.

Send the <u>original petition to your local WCAB office</u> and a <u>copy</u> to:

Return-to-Work Supplemental Program (RTWSP)
Department of Industrial Relations
Attn: Appeals
1515 Clay Street, 17th Floor
Oakland, CA 94612-1499

Submit the following documents with your form filing <u>in the order shown</u>:

- ✓ Document Cover Sheet
- ✓ Document Separator Sheet (*for Appeal of Director's Return to Work Supplement Decision)*
- ✓ Petition Appeal of Director's Return To Work Supplement Decision
- ✓ Verification
- ✓ Document Separator Sheet (*Correspondence – other*)
- ✓ Notice of Benefit Ineligibility Letter (*Copy of the Letter)*
- ✓ Document Separator Sheet (*for Proof of Service by Mail*)
- ✓ Proof of Service by Mail

Keep copies of your filings for your records.

Once the petition is received, the Director's Office may file an answer to your petition within 20 days of the date of service of the petition.

If you have an ADJ case number starting with a zero "0" (i.e. ADJ**0**12345678), it means you were issued a temporary ADJ number. In order to receive a valid ADJ case number, you will need to submit an "Application for Adjudication of Claim". To do this, please see I&A guide 4: https://www.dir.ca.gov/dwc/iwguides/IWGuides04.pdf. All other ADJ case numbers are valid.

In order to have your petition addressed by a judge, you must also complete and file a "Declaration of Readiness to Proceed" (DOR). For instructions on how to complete and file a DOR, please see I&A guide 5: https://www.dir.ca.gov/dwc/iwguides/IWGuide05.pdf. **Please file the DOR 30 days after the service date of the petition.**

All documents filed with the WCAB must include a document cover sheet and document separator sheet. Please see I&A guides 17 and 18 to learn how to complete these forms. Additional form instructions can be found on the EAMS OCR handbook at http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf.

If you need help, call an Information and Assistance (I&A) office, or attend a workshop for injured workers. The local I&A phone numbers are attached to this guide. You can get information on a local workshop from the I&A office or on the Web at www.dwc.ca.gov.

WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

- **ANAHEIM, 92806-2131**
  1065 North Link, Suite 170
  Information & Assistance Unit **(714) 414-1801**

- **BAKERSFIELD, 93301-1929**
  1800 30th Street, Suite 100
  Information & Assistance Unit **(661) 395-2514**

- **FRESNO, 93721-2219**
  2550 Mariposa Street, Suite 4078
  Information & Assistance Unit **(559) 445-5355**

- **LODI, 95240-6936**
  3021 Reynolds Ranch Parkway, Suite 130
  Information & Assistance Unit **(209) 948-7759**

- **LONG BEACH, 90810-1870**
  1500 Hughes Way, Suite C203
  Information & Assistance Unit **(424) 450-2565**

- **LOS ANGELES, 90013-1105**
  320 W 4th Street, 9th Floor
  Information & Assistance Unit **(213) 576-7389**

- **MARINA DEL REY, 90292-6902**
  4720 Lincoln Boulevard, 2nd and 3rd Floors
  Information & Assistance Unit **(310) 482-3820**

- **OAKLAND, 94612-1499**
  1515 Clay Street, 6th Floor
  Information & Assistance Unit **(510) 622-2861**

- **OXNARD, 93030-7912**
  1901 N Rice Avenue, Suite 100
  Information & Assistance Unit **(805) 485-3528**

- **POMONA, 91768-1653**
  732 Corporate Center Drive
  Information & Assistance Unit **(909) 623-8568**

- **REDDING, 96002-0940**
  250 Hemsted Drive, 2nd Floor, Suite B
  Information & Assistance Unit **(530) 225-2047**

- **RIVERSIDE, 92501-3337**
  3737 Main Street, Suite 300
  Information & Assistance Unit **(951) 782-4347**

- **SACRAMENTO, 95834-2962**
  160 Promenade Circle, Suite 300
  Information & Assistance Unit **(916) 928-3158**

- **SALINAS, 93906-2204**
  1880 N Main Street, Suites 100 & 200
  Information & Assistance Unit **(831) 443-3058**

- **SAN BERNARDINO, 92401-1411**
  464 W Fourth Street, Suite 239
  Information & Assistance Unit **(909) 383-4522**

- **SAN DIEGO, 92108-4424**
  7575 Metropolitan Drive, Suite 202
  Information & Assistance Unit **(619) 767-2082**

- **SAN FRANCISCO, 94102-7014**
  455 Golden Gate Avenue, 2nd Floor
  Information & Assistance Unit **(415) 703-5020**

- **SAN JOSE, 95110-3718**
  224 Airport Parkway, Suite 600
  Information & Assistance Unit **(408) 277-1292**

- **SAN LUIS OBISPO, 93401-8736**
  4740 Allene Way, Suite 100
  Information & Assistance Unit **(805) 596-4159**

- **SANTA ANA, 92707-7704**
  2 MacArthur Place, Suite 600
  Information & Assistance Unit **(714) 942-7576**

- **SANTA BARBARA, 93101-7538**
  130 E Ortega Street
  Information & Assistance Unit **(805) 568-1390**

- **SANTA ROSA, 95404-4771**
  50 "D" Street, Suite 420
  Information & Assistance Unit **(707) 576-2452**

- **VAN NUYS, 91401-3370**
  6150 Van Nuys Boulevard, Suite 105
  Information & Assistance Unit **(818) 901-5374**

Reset Form | Print Form

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☐ No ☐ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☐

More than 15 Companion Cases ☐

Date:(MM/DD/YYYY) _____ SSN: _____

Case Number 1 _____ ☐ Specific Injury ☐ Cumulative Injury (Start Date: MM/DD/YYYY) _____ (End Date: MM/DD/YYYY) _____

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

Please check unit to be filed on (check only one box)

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ SAU ☐ INT ☐ RSU

Companion Cases

Case Number 2 _____ ☐ Specific Injury ☐ Cumulative Injury (Start Date: MM/DD/YYYY) _____ (End Date: MM/DD/YYYY) _____

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

Case Number 3

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 4

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 5

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 6

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 7

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 8

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 9

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 10

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 11

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 12

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 13

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 14

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 15

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 16

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

SAMPLE

DOCUMENT COVER SHEET

Is this a new case? Yes ☐ No ☐ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☐

More than 15 Companion Cases ☐

TODAY'S DATE

Date:(MM/DD/YYYY)

SSN: YOUR SOCIAL SECURITY NUMBER

EAMS CASE NUMBER

Case Number 1

☐ Specific Injury

☐ Cumulative Injury

DATE OF INJURY

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

IF NEW CASE LEAVE BLANK

Body Part 1: _____ ← USE CODE FROM BODY PART CODE LIST -- SEE PAGE 8

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: WHEN MORE THAN 5 BODY PARTS USE BODY PART NUMBER 700 IN THIS FIELD

Please check unit to be filed on (check only one box)

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ SAU ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

District office codes for place of venue

Legend Abbreviation	Office
AHM	Anaheim
ANA	Santa Ana
BAK	Bakersfield
FRE	Fresno
LAO	Los Angeles
LBO	Long Beach
LOD	Lodi
MDR	Marina del Rey
OAK	Oakland
OXN	Oxnard
POM	Pomona
RDG	Redding
RIV	Riverside
SAC	Sacramento
SAL	Salinas
SBA	Santa Barbara
SBR	San Bernardino
SDO	San Diego
SFO	San Francisco
SJO	San Jose
SLO	San Luis Obispo
SRO	Santa Rosa
VNO	Van Nuys

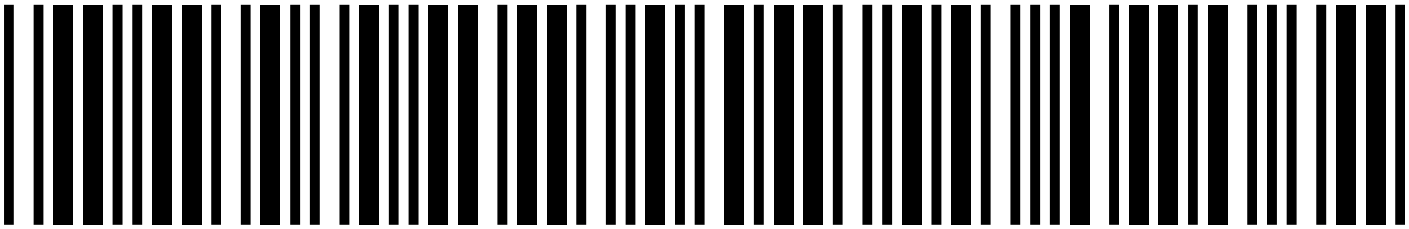
Use this document to complete forms,
but do not file this document with your forms.

BODY PART CODES LIST

Code Number	Description
100	Head - not specified
110	Brain
120	Ear - not specified
121	Ear - external
124	Ear - internal including hearing
130	Eye - including optic nerves and vision
140	Face - not specified
141	Jaw - including chin and mandible
144	Mouth - including lips, tongue, throat and taste
145	Teeth
146	Nose - including nasal passages, sinus and smell
148	Face - multiple parts any combination of above parts
149	Face - forehead, cheeks, eyelids
150	Scalp
160	Skull
198	Head - multiple injury any combination of above parts
200	Neck
300	Upper extremities - not specified
310	Arm - above wrist not specified
311	Arm - upper arm humerus
313	Arm - elbow head of radius
315	Arm - forearm radius and ulna
318	Arm - multiple parts any combination of above parts
319	Arm - not specified
320	Wrist
330	Hand - not wrist or fingers
340	Fingers
398	Upper extremities - multiple parts any combination of above parts
400	Trunk - not specified
410	Abdomen - including internal organs and groin
411	Hernia
420	Back - including back muscles, spine and spinal cord
430	Chest - including ribs, breast bone and internal organs of the chest
440	Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks
450	Shoulders - scapula and clavicle
498	Trunk - use for side; multiple parts any combination of above parts

Code Number	Description
500	Lower extremities - not specified
510	Legs - above ankles, not specified
511	Thigh femur
513	Knee Patella
515	Lower leg tibia and fibula
518	Leg - multiple parts any combination of above parts
519	Leg - not specified
520	Ankle malleolus
530	Foot not ankle or toe
540	Toes
598	Lower extremities - multiple parts any combination of above parts
700	Multiple parts more than five major parts use only in fifth position of listing of body parts
800	Body system - not specific
801	Circulatory system - heart - other than heart attack, blood, arteries, veins, etc.
802	Circulatory system - Heart attack
810	Digestive system - stomach
820	Excretory system - kidneys, bladder, intestines, etc.
830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
840	Nervous system - not specified
841	Nervous system - Stress
842	Nervous system - Psychiatric/psych
850	Respiratory system - lungs, trachea, etc.
860	Skin dermatitis, etc.
870	Reproductive systems
880	Other body systems
900	COVID-19
999	Unclassified - insufficient information to identify body parts

DOCUMENT SEPARATOR SHEET



Product Delivery Unit _____

Document Type _____

Document Title _____

Document Date _____
MM/DD/YYYY

Author _____

Office Use Only

Received Date _____
MM/DD/YYYY

SAMPLE

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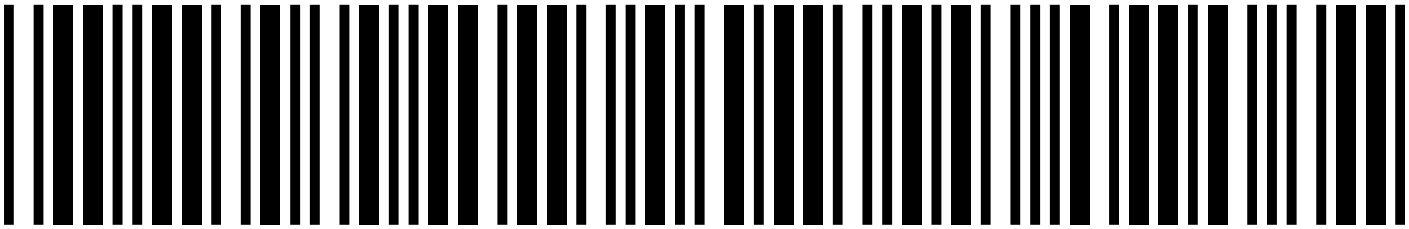


Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: APPEAL OF DIRECTOR'S RETURN TO WORK SUPPLEMENT DECISION

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date
MM/DD/YYYY

NAME:
STREET:
CITY, STATE, ZIP CODE:
TELEPHONE #:

STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

Applicant, vs. Defendants.	ADJ #: RTWSP Application #: PETITION APPEALING DENIAL OF RETURN-TO-WORK SUPPLEMENT

A decision was filed in the above-entitled case on _____.

The _____ is aggrieved by said decision and hereby petitions for reconsiderations upon the following grounds (strike out items not applicable):

1. By the order, decision or award, the Board acted without or in excess of its powers.
2. The order, decision, or award was procured by fraud.
3. The evidence does not justify the findings of fact.
4. Petitioner has discovered new evidence material to him with he could not with reasonable diligence have discovered and produced at the hearing.
5. The findings of fact do not support the order, decision or award.

In support of the above, petitioner gives the following details, including a statement of facts upon which petitioner relies and a discussion of the law applicable thereto:

_____ _____

Your Signature Date

SAMPLE

NAME: Your Name
STREET: Your Address
CITY, STATE, ZIP CODE:
TELEPHONE #: Your Telephone Number

STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

Your Name Applicant, vs. Your Employer and Insurance Company Defendants.	ADJ #: EAMS case number RTWSP Application #: See Notice of Benefit Ineligibility letter from RTWSP Unit PETITION APPEALING DENIAL OF RETURN-TO-WORK SUPPLEMENT

A decision was filed in the above-entitled case on Date the RTWSP Unit decision was issued

The Your Name is aggrieved by said decision and hereby petitions for reconsiderations upon the following grounds (strike out items not applicable):

1. By the order, decision or award, the Board acted without or in excess of its powers.
2. The order, decision, or award was procured by fraud.
3. The evidence does not justify the findings of fact.
4. Petitioner has discovered new evidence material to him with he could not with reasonable diligence have discovered and produced at the hearing.
5. The findings of fact do not support the order, decision or award.

In support of the above, petitioner gives the following details, including a statement of facts upon which petitioner relies and a discussion of the law applicable thereto:

Explain in your own words why you feel you are entitled to these benefits.

Your Signature
_____
Your Signature

Today's Date
_____
Date

VERIFICATION

STATE OF CALIFORNIA

County of _____

I, the undersigned, say that I am _____, a party to this action. I have read the foregoing **Petition Appealing Denial of Return-to Work Supplement** and know the contents thereof, and that the same is true of my own knowledge, except as to the matters which are therein stated upon my information or belief, and as to those matters that I believe to be true.

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

Executed on _____, at _____, California.

_____
Petitioner

Sample

VERIFICATION

STATE OF CALIFORNIA

County of your county

I, the undersigned, say that I am your name, a party to this action. I have read the foregoing **Petition Appealing Denial of Return-to Work Supplement** and know the contents thereof, and that the same is true of my own knowledge, except as to the matters which are therein stated upon my information or belief, and as to those matters that I believe to be true.

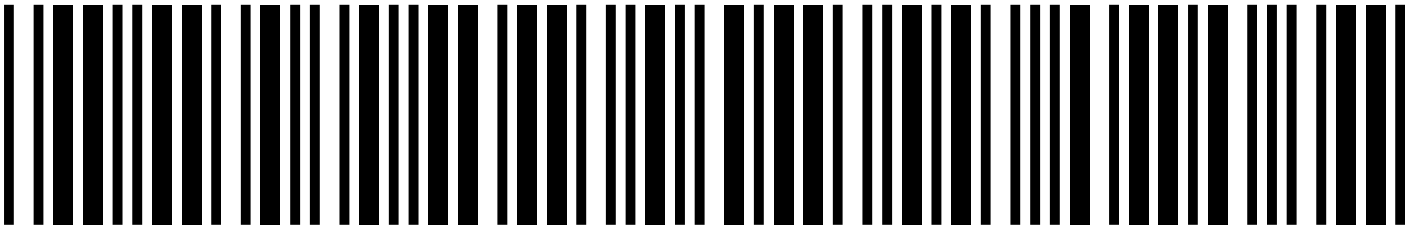
I declare under penalty of perjury that the foregoing is true and correct.

Executed on date mailed, at your city, California.

your signature

Petitioner

DOCUMENT SEPARATOR SHEET



Product Delivery Unit _____

Document Type _____

Document Title _____

Document Date _____
MM/DD/YYYY

Author _____

Office Use Only

Received Date _____
MM/DD/YYYY

SAMPLE

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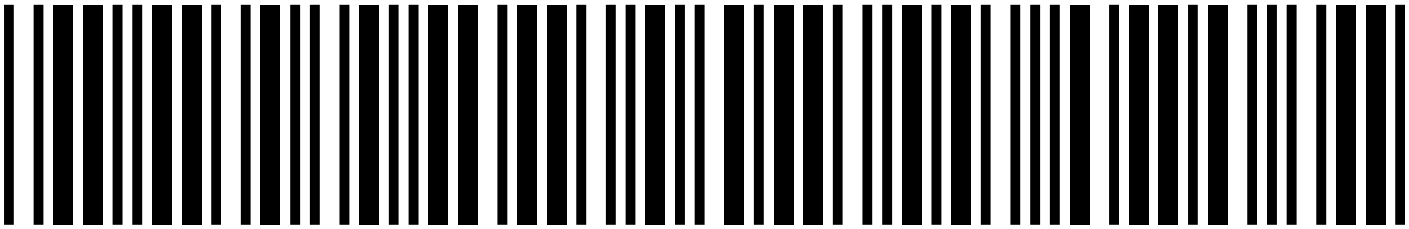


Product Delivery Unit: ADJ

Document Type: MISC

Document Title: CORRESPONDENCE - OTHER

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date
MM/DD/YYYY

STATE OF CALIFORNIA EDMUND G. BROWN JR., *Governor*
DEPARTMENT OF INDUSTRIAL RELATIONS
Office of the Director
Return-to-Work Supplement Program

Mailing Address:
RTW Supplement Program
1515 Clay Street, 17th Floor
Oakland, CA 94612
510-286-0787

November 21, 2017

APPLICANT'S FN & LN
APPLICANT'S STREET ADDDRESS
CITY, STATE, ZIP CODE

NOTICE OF BENEFIT INELIGIBILITY

RE: RTWSP Application No.: RTW10XXXXX
RTWSP Application DOI: 08/04/2014

Dear APPLICANT'S FN & LN

Thank you for your interest in the Return-to-Work Supplement program. Your application was carefully reviewed and was determined ineligible for the Return-to-Work Supplement.

A $5000.00 RTWSP check was previously issued to you. Per § 17302(b) of the California Code of Regulations, an individual who has received a Return-to-Work Supplement may not receive a second or subsequent Return-to-Work Supplement, except where the individual receives a Voucher for an injury which occurs subsequent to receipt of every previous Return-to-Work Supplement.

If you disagree with this notice of ineligibility, you may file an appeal at the DWC district office within 20 days of receipt of this ineligibility determination. The appeal must include your full name, ADJ number of the case in which the SJDB voucher was provided, and a clear and concise statement of the facts constituting the basis for your appeal.

A copy of the appeal must be served on the Return-to-Work Supplement Program as follows:

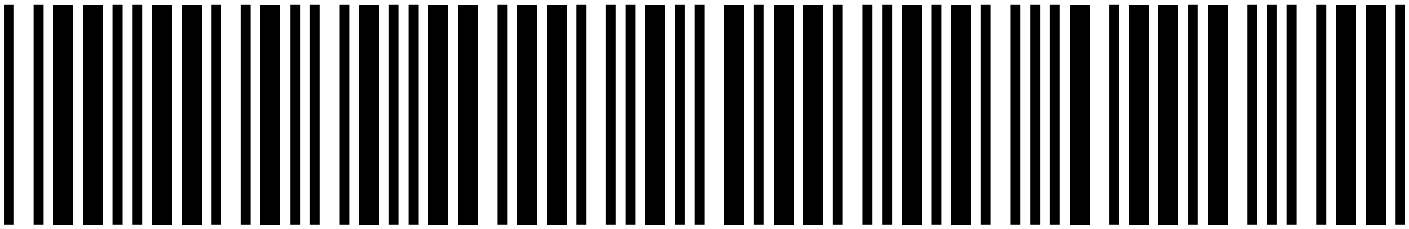
Return-to-Work Supplement Program
Department of Industrial Relations
ATTN: Appeals
1515 Clay St, 17th floor
Oakland, CA 94612

Please contact 510-286-0787 or RTWSP@dir.ca.gov if you have any questions regarding this matter.

Very truly yours,

RTW Reviewer
Return-to-Work Supplement Program
(510) 286-0787
Email: RTWSP@dir.ca.gov

DOCUMENT SEPARATOR SHEET



Product Delivery Unit _____

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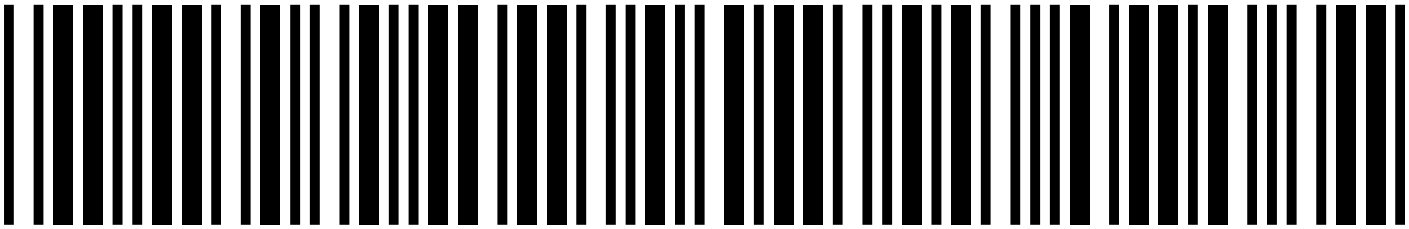

Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: PROOF OF SERVICE

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date
MM/DD/YYYY

Proof of Service by Mail

I declare that:

I am (resident of / employed in) the county of _____, California. I am over the age of eighteen years, my (business / residence) address is:

On _____, I served the attached _____ on the parties listed below in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at _____ addressed as follows:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) _____, at _____, California.

Type or print name _____

Signature _____

SAMPLE

Proof of Service by Mail

I declare that:

I am (resident of / employed in) the county of YOUR COUNTY, California.

I am over the age of eighteen years, my (business / residence) address is:

PUT YOUR HOME ADDRESS HERE

On TODAY'S DATE, I served the attached APPEAL OF DIRECTOR'S RTW SUPPLEMENT DECISION on the parties listed RTWSP UNIT case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at CITY WHERE YOU MAILED THIS addressed as follows:

1) RETURN-TO-WORK SUPPLEMENT PROGRAM (RTWSP)
DEPARTMENT OF INDUSTRIAL RELATIONS
ATTN: APPEALS
1515 CLAY ST., 17TH FLOOR
OAKLAND, CA 94612-1499
2) WORKERS' COMPENSATION APPEALS BOARD: ADDRESS

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) TODAY'S DATE, at CITY, California.

Type or print name PRINT YOUR NAME

Signature SIGN YOUR NAME