WORKERS' COMPENSATION GRIEVANCE

UNDER THE
WORKERS' COMPENSATION ADDENDUM

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Case No.________________

______________________________ (Employee's Name)	______________________________ (Employer's Name)
______________________________ (Social Security Number)	______________________________ (Street Address)
______________________________ (Street Address)	______________________________ (City, State & Zip Code)
______________________________ (City, State & Zip Code)	

If other, name, etc.:____

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1. While employed as a ________________ on ____________ at ________________
(occupation at time of injury) (date of injury) (name and location of job site)

by the employer, the employee sustained injury arising out of and in the course of employment to ______________
____.
(state what parts of the body were injured)

2. The injury occurred as follows: ____
(explain what employee was doing at time of injury and how injury was received.)
____.

3. Days off work because of the injury: ____.
(specify the number of days off work and the dates for those days)

4. Medical treatment was received _____ _____ ________________. Medical treatment was provided by ____
(yes) (no) (date of last treatment)
____
(name and address of all medical providers)
____
(name and address of all medical providers)

5. This Grievance is filed because of a dispute about: Temporary Disability Payments ________ Permanent Disability Payments ________ Reimbursement for Medical Expense ________ Compensation at the Proper Rate _______ Rehabilitation ________

Medical Treatment (Explain): ____.

Other (Explain): ____.

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Date: ______________________________

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(Signature, or Attorney's if Represented)

Must be timely filed with the Director of the Alternative Dispute Prevention and Resolution System,
533 South Fremont Avenue, Suite 800
Los Angeles, California, 90071; (213) 312-9311,
Email: weiss@fortunealsweet.com

Form 103; 6/16/22