

WORKERS' COMPENSATION
GRIEVANCE

UNDER THE
WORKERS' COMPENSATION ADDENDUM

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.: _____
=====

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): _____
=====

Date: _____

(Signature, or Attorney's if Represented)

Must be timely filed with the Director of the Alternative Dispute
Prevention and Resolution System,
445 South Figueroa Street, Suite 2625
Los Angeles, California, 90071; (213) 312-9311,
Email: weiss@fortunealsweet.com