

COMPLAINT
UNDER THE
Ironworkers Collectively Bargained Workers' Compensation Program

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 _____
(occupation at time of injury) (date of injury)

at _____ by the employer, the employee sustained injury arising out of and in the
(name and location of job site)

course of employment to _____
(state what parts of the body were injured)

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

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: _____
(yes) (no) (date of last treatment)

Medical treatment was provided by _____
(name and address of all medical providers)

5. This Complaint is filed because of a dispute about: Temporary Disability Payments ___ Permanent Disability Payments' _____

Reimbursement for Medical Expenses: _____ Compensation at the Proper Rate: _____ Rehabilitation: _____ Medical Treatment _____

Other (Explain) _____

(Date)

(Employee's Signature, or Attorney's if represented)

Must be filed with the ADR Ombudsman:
Eric J. Nobriga Sr.
Ironworkers Collectively Bargained Workers Compensation Program
2120 Foothill Blvd., Suite 100
La Verne, CA 91750
Office: (626) 356-3051 or (888) 615-4766; Fax: (866) 322-2044