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 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: _____ _____ _____.
(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 Administrator:
Gene Vick
Ironworkers Collectively Bargained Workers Compensation Program
P.O. Box 542, El Verano, CA 95433-9998
Telephone: (888) 615-4766; Fax: (707) 935-8826