

**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