

# DISPUTE RESOLUTION FORM

Date: \_\_\_\_\_

From:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

RE: Claimant Name: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Description and Summary of Dispute:

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Please attach any supporting documentation that should be considered.

Please submit to: The Administrator of the Certified Case Management Plan  
Jerry Gravatt  
Stubbe Dakota Case Management  
329-A East St. Joseph Street  
Rapid City, SD 57701

It is the goal of the case management plan to resolve this issue within 30 days of receipt of this form. At that time, should resolution not be achieved, or there continues to be dissatisfaction of the results, an appeal may be made to the South Dakota Department of Labor.