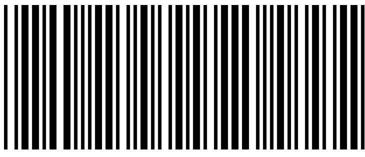
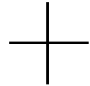
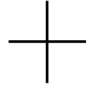


STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD



Date of Injury ____________________
MM/DD/YYYY

____
Case No.



____
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

____
Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Applicant (Completion of this section is required)

______________________________ ___
First Name MI

____
Last Name

____
Address/PO Box (Please leave blank spaces between numbers, names or words)

______________________________ ______ __________
City State Zip Code

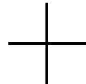
Employer #1 Information (Completion of this section is required)

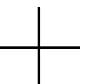
☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

____
Employer Name (Please leave blank spaces between numbers, names or words)

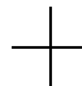
____
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

______________________________ ______ __________
City State Zip Code





Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)



Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

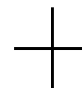
City | State | Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

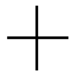
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code



Claims Administrator Information (if known and if applicable)



Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #3 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

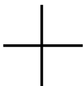
City State Zip Code

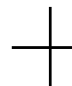
Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

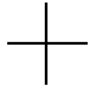
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code





Employer #4 Information (Completion of this section is required)



☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

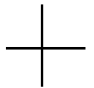
Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:



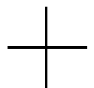
1. ______________________
Employees First Name

______________________ ,
Employees Last Name

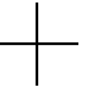
birth date ______________ ,
MM/DD/YYYY

while employed at ______________________ , ________
State

as a(n) ______________________ , ________ in
Occupation Group



☐ More than 4 Companion Cases



☐ Specific Injury

Case Number 1 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 2 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 3 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 4 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

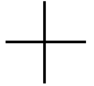
Body Part 4: Other Body Parts:

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

(Please list all body parts injured)

2. The injury (ies) caused temporary disability for the period ______________ through
MM/DD/YYYY

______________ for which indemnity has been paid at $ ______________ per week.
MM/DD/YYYY Indemnity Paid



2(a).The injury(ies) caused additional temporary disability for the period ______________
MM/DD/YYYY

through ______________ at the rate of $ ______________ in the amount of $ ______________
MM/DD/YYYY Rate Indemnity Paid

3. The injury(ies) caused permanent disability of ______________ % for which indemnity is payable at $ ______________
Indemnity Rate

per week beginning ______________ in the sum of $ ______________ , less credit for such payments
MM/DD/YYYY

previously made. ☐ And a life pension of $ ______________ per week thereafter.
Life Pension

An informal rating ☐ has / ☐ has not (Select one) been previously issued in case no(s) ______________ .

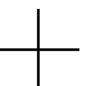
4.There ☐ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

6. Applicant's attorney requests a fee of $ ______________

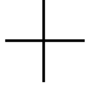
☐ Fees to be commuted as follows:

7. Liens Against compensation are payable as follows:



8.Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

9.Other stipulations:

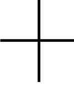


Dated ______________________ MM/DD/YYYY

______________________ Applicant

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative



First Name

Last Name

Firm Number

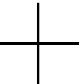
Law Firm name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

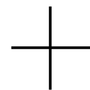
Dated ______________________ MM/DD/YYYY

______________________ Applicant Attorney Signature



Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative



First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

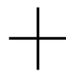
Law Firm Name

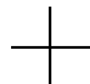
Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated MM/DD/YYYY

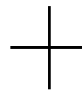
Defense Attorney Signature





Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative



First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Dated ____________ MM/DD/YYYY

Defense Attorney Signature

Interpreter License Number:

Interpreter Name

Interpreter License Number