

Information & Assistance Unit guide 4

How to file an application for adjudication of claim

Complete this form if you have a disagreement with your employer or its insurance company about your case and you want it resolved by your local Workers' Compensation Appeals Board (WCAB). Filing this form opens a case with the WCAB.

You can also complete this form if you think you may need the WCAB to resolve a dispute in the future and the time allowed for you to file the application could run out. If you have questions about whether time limits apply in your case, contact your local Information and Assistance office. You can get information on contacting a local I&A office on the Web at www.dwc.ca.gov.

Complete the form and follow the instructions attached. This form can also be completed at <http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWC1.pdf>.

Please note that a hearing in your case will not be scheduled until a declaration of readiness to proceed is filed (see I&A guide 5).

The following papers must be included with your completed application:

1. A copy of your claim for workers' compensation benefits (required only for injuries that happened between 1-1-90 and 12-31-93). See I&A guide 1.
2. Declaration required by law (Labor Code section 4906(h) -- see attached). A proof of service is recommended. See attached.

Send the original to your local WCAB office and copies to all the parties.

Submit the following documents with your form filing in the order shown:

- ✓ [Document Cover Sheet](#)
- ✓ [Document Separator Sheet](#) (*for Application for Adjudication of Claim*)
- ✓ [Application for Adjudication of Claim](#)
- ✓ [Document Separator Sheet](#) (*for Proof Of Service By Mail*)
- ✓ [Proof Of Service By Mail](#)
- ✓ [Document Separator Sheet](#) (*for Declaration Pursuant to Labor Code Section 4906(h)*)
- ✓ [Declaration Pursuant to Labor Code Section 4906\(h\)](#)

Keep copies of your filings for your records.

Information & Assistance Unit guide 4

All documents filed with the WCAB must include a document cover sheet and document separator sheet. Please see I&A guides 17 and 18 to learn how to complete these forms. In addition all forms must be typed or handwritten in block letters to insure legibility. Additional form instructions can be found on the EAMS OCR handbook at http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf.

If you need help, call an [Information and Assistance \(I&A\) office](#), or attend a [workshop for injured workers](#). The local I&A phone numbers are attached to this guide. You can get information on a local workshop from the I&A office or on the Web at www.dwc.ca.gov.

If you do not have the name and address of your claims administrator to complete a form, please link to <http://www.dir.ca.gov/DWC/EAMS/EAMS-LC/EAMSClaimsAdmins.asp>.

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations different than those present here.

When sending documents to a district office, please make sure they are not folded or stapled. Send them in a large manila envelope. Please see the EAMS OCR forms handbook for further instructions.

WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

ANAHEIM, 92806-2131

1065 North Link, Suite 170
Information & Assistance Unit (714) 414-1801

BAKERSFIELD, 93301-1929

1800 30th Street, Suite 100
Information & Assistance Unit (661) 395-2514

EUREKA, 95501-0529 * Virtual office *

Information & Assistance Unit
(707) 441-5723

FRESNO, 93721-2219

2550 Mariposa Street, Suite 4078
Information & Assistance Unit (559) 445-5355

LODI, 95240-6936

3021 Reynolds Ranch Parkway, Suite 130
Information & Assistance Unit (209) 948-7980

LONG BEACH, 90810-1870

1500 Hughes Way, Suite C203
Information & Assistance Unit (424) 450-2565

LOS ANGELES, 90013-1105

320 W 4th Street, 9th Floor
Information & Assistance Unit (213) 576-7389

MARINA DEL REY, 90292-6902

4720 Lincoln Boulevard, 2nd and 3rd Floors
Information & Assistance Unit (310) 482-3820

OAKLAND, 94612-1499

1515 Clay Street, 6th Floor
Information & Assistance Unit (510) 622-2861

OXNARD, 93030-7912

1901 N Rice Avenue, Suite 100
Information & Assistance Unit (805) 485-3528

POMONA, 91768-1653

732 Corporate Center Drive
Information & Assistance Unit (909) 623-8568

REDDING, 96002-0940

250 Hemsted Drive, 2nd Floor, Suite B
Information & Assistance Unit (530) 225-2047

RIVERSIDE, 92501-3337

3737 Main Street, Suite 300
Information & Assistance Unit (951) 782-4347

SACRAMENTO, 95834-2962

160 Promenade Circle, Suite 300
Information & Assistance Unit (916) 928-3158

SALINAS, 93906-2204

1880 N Main Street, Suites 100 & 200
Information & Assistance (831) 443-3058

SAN BERNARDINO, 92401-1411

464 W Fourth Street, Suite 239
Information & Assistance Unit (909) 383-4522

SAN DIEGO, 92108-4424

7575 Metropolitan Drive, Suite 202
Information & Assistance Unit (619) 767-2082

SAN FRANCISCO, 94102-7014

455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit (415) 703-5020

SAN JOSE, 95110-3718

224 Airport Parkway, Suite 600
Information & Assistance Unit (408) 277-1292

SAN LUIS OBISPO, 93401-8736

4740 Allene Way, Suite 100
Information & Assistance Unit (805) 596-4159

SANTA ANA, 92707-7704

2 MacArthur Place, Suite 600
Information & Assistance Unit (714) 942-7576

SANTA BARBARA, 93101-7538

130 E Ortega Street
Information & Assistance Unit (805) 568-1390

SANTA ROSA, 95404-4771

50 "D" Street, Suite 420
Information & Assistance Unit (707) 576-2452

VAN NUYS, 91401-3370

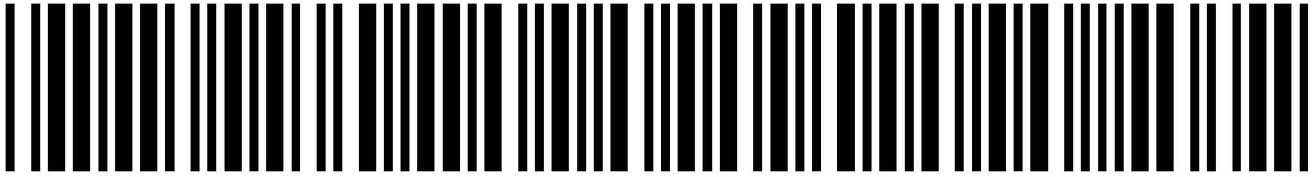
6150 Van Nuys Boulevard, Suite 105
Information & Assistance Unit (818) 901-5374



STATE OF CALIFORNIA
DWC DISTRICT OFFICE

SAMPLE

DOCUMENT COVER SHEET



Is this a new case? Yes No Companion Cases Exist Walkthrough Yes No

More than 15 Companion Cases

TODAY'S DATE

Date:(MM/DD/YYYY)

SSN: **YOUR SOCIAL SECURITY NUMBER**

EAMS CASE NUMBER

Case Number 1

Specific Injury

DATE OF INJURY

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)

IF NEW CASE LEAVE BLANK

USE CODE FROM BODY PART CODE LIST -- SEE PAGE 8

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

WHEN MORE THAN 5 BODY PARTS USE BODY PART NUMBER 700 IN THIS FIELD

Other Body Parts: _____

Please check unit to be filed on (check only one box)

ADJ DEU SIF UEF SAU INT RSU

Companion Cases

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 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____



District office codes for place of venue

Legend Abbreviation	Office
AHM	Anaheim
ANA	Santa Ana
BAK	Bakersfield
EUR	Eureka*
FRE	Fresno
LAO	Los Angeles
LBO	Long Beach
LOD	Lodi
MDR	Marina del Rey
OAK	Oakland
OXN	Oxnard
POM	Pomona
RDG	Redding
RIV	Riverside
SAC	Sacramento
SAL	Salinas
SBA	Santa Barbara
SBR	San Bernardino
SDO	San Diego
SFO	San Francisco
SJO	San Jose
SLO	San Luis Obispo
SRO	Santa Rosa
VNO	Van Nuys

* Eureka is a virtual office.

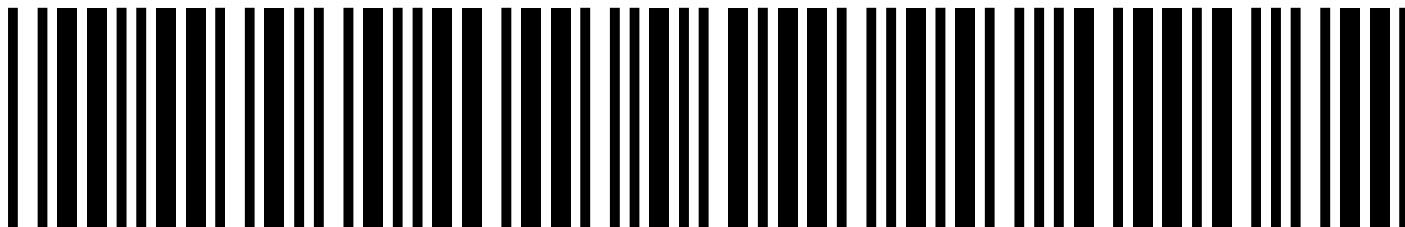
**Use this document to complete forms,
but do not file this document with your forms.**

BODY PART CODES LIST

Code Number	Description
100	Head - not specified
110	Brain
120	Ear - not specified
121	Ear - external
124	Ear - internal including hearing
130	Eye - including optic nerves and vision
140	Face - not specified
141	Jaw - including chin and mandible
144	Mouth - including lips, tongue, throat and taste
145	Teeth
146	Nose - including nasal passages, sinus and smell
148	Face - multiple parts any combination of above parts
149	Face - forehead, cheeks, eyelids
150	Scalp
160	Skull
198	Head - multiple injury any combination of above parts
200	Neck
300	Upper extremities - not specified
310	Arm - above wrist not specified
311	Arm - upper arm humerus
313	Arm - elbow head of radius
315	Arm - forearm radius and ulna
318	Arm - multiple parts any combination of above parts
319	Arm - not specified
320	Wrist
330	Hand - not wrist or fingers
340	Fingers
398	Upper extremities - multiple parts any combination of above parts
400	Trunk - not specified
410	Abdomen - including internal organs and groin
411	Hernia
420	Back - including back muscles, spine and spinal cord
430	Chest - including ribs, breast bone and internal organs of the chest
440	Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks
450	Shoulders - scapula and clavicle
498	Trunk - use for side; multiple parts any combination of above parts

Code Number	Description
500	Lower extremities - not specified
510	Legs - above ankles, not specified
511	Thigh femur
513	Knee Patella
515	Lower leg tibia and fibula
518	Leg - multiple parts any combination of above parts
519	Leg - not specified
520	Ankle malleolus
530	Foot not ankle or toe
540	Toes
598	Lower extremities - multiple parts any combination of above parts
700	Multiple parts more than five major parts use only in fifth position of listing of body parts
800	Body system - not specific
801	Circulatory system - heart - other than heart attack, blood, arteries, veins, etc.
802	Circulatory system - Heart attack
810	Digestive system - stomach
820	Excretory system - kidneys, bladder, intestines, etc.
830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
840	Nervous system - not specified
841	Nervous system - Stress
842	Nervous system - Psychiatric/psych
850	Respiratory system - lungs, trachea, etc.
860	Skin dermatitis, etc.
870	Reproductive systems
880	Other body systems
900	COVID-19
999	Unclassified - insufficient information to identify body parts

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

APPLICATION FOR ADJUDICATION

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

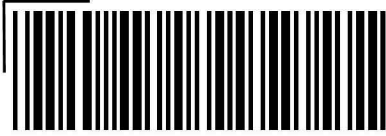
Author

YOUR NAME

Office Use Only

Received Date

MM/DD/YYYY



STATE OF CALIFORNIA
 DIVISION OF WORKERS' COMPENSATION
 WORKERS' COMPENSATION APPEALS BOARD
 APPLICATION FOR ADJUDICATION OF CLAIM

SAMPLE

LEAVE BLANK

Amended Application

Case No. _____

YOUR SOCIAL SECURITY NUMBER

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 ONE**

USE 3 LETTER OFFICE CODE FROM DOCUMENT COVER SHEET

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

Injured Worker (Completion of this section is required)

YOUR FIRST NAME

First Name _____ MI _____

YOUR LAST NAME

Last Name _____

YOUR MAILING ADDRESS

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words) _____

International Address (Please leave blank spaces between numbers, names or words) _____

YOUR CITY

City _____ State _____ Zip Code _____

Applicant (If other than Injured Worker)

- Insurance Carrier Employer Lien Claimant

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

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Employer Information (Completion of this section is required)

SAMPLE

Insured Self-Insured Legally Uninsured Uninsured

NAME OF COMPANY YOU WERE WORKING FOR AT TIME OF INJURY

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

COMPANY ADDRESS

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

COMPANY CITY

City _____ State _____ Zip Code _____

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

NAME OF COMPANY INSURANCE CARRIER

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

INSURANCE CARRIER ADDRESS

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

INSURANCE CARRIER CITY

City _____ State _____ Zip Code _____

Claims Administrator Information (If known and if applicable)

NAME OF CLAIMS ADMINISTRATOR

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

CLAIMS ADMINISTRATOR ADDRESS

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

CLAIMS ADMINISTRATOR CITY

City _____ State _____ Zip Code _____

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born **YOUR BIRTH DATE** (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) **YOUR JOB TITLE WHEN INJURED** (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

specific injury **DATE OF ACCIDENT** (Date of injury: MM/DD/YYYY)

suffered a :

cumulative injury which began on _____ (Start Date: MM/DD/YYYY) and ended on _____ (End Date: MM/DD/YYYY)

The injury occurred at **ADDRESS WHERE ACCIDENT TOOK PLACE**

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

City _____ State _____ Zip Code _____

(State which parts of the body were injured)

SAMPLE

Body Part 1: **PART OF BODY THAT WAS INJURED, USE LIST FROM DOCUMENT COVER SHEET**

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

INDICATE WHAT YOU WERE DOING AT THE TIME OF INJURY

3. Actual earnings at the time of injury:

Rate of Pay \$ _____ Monthly Weekly Hourly

State value of tips, meals, lodging, or other advantages, regularly received \$ _____ Monthly Weekly Hourly

Number of hours worked per week _____

4. The injury caused disability as follows:

Last day off work due to injury: **LAST DAY WORKED**
MM/DD/YYYY

First Period of Disability: Start Date **FIRST DAY OFF WORK** End Date **DATE RETURNED TO WORK**
MM/DD/YYYY MM/DD/YYYY

Second Period of Disability: Start Date _____ End Date _____
MM/DD/YYYY MM/DD/YYYY

5. Compensation:

Compensation was paid: Yes No

Total paid: _____

Weekly rate(s): **FROM CLAIMS ADMINISTRATOR**

Date of last payment: _____
MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury?

Yes No

7. Medical treatment:

Medical treatment was received:

Yes No

SAMPLE

All treatment was furnished by the Employer or Insurance Carrier:

Yes No

Date of last treatment: _____
MM/DD/YYYY

**IF YOU OR PRIVATE INSURANCE PAID
FOR MEDICAL TREATMENT**

Other treatment was provided/paid by: _____

(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim?

Yes No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

LIST ANY OTHER CASES FILED WITH DWC

Case Number 1

Case Number 3

Case Number 2

Case Number 4

9. This application is filed because of a disagreement regarding liability for:

Temporary disability indemnity

Permanent disability indemnity

Reimbursement for medical expense

Rehabilitation

Medical treatment

Supplemental Job Displacement/Return to Work

Compensation at proper rate

Other (Specify) _____



Is the Applicant Represented? Yes No If "No", applicant is to sign and date below.

SAMPLE

If "Yes", applicant's representative is to complete the following and is to sign and date below.

Law Firm/Attorney Non-Attorney Representative

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name _____
MI

Attorney/Representative Last Name

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

City _____
State _____
Zip Code

YOUR SIGNATURE

Applicant Attorney/Representative Signature

Applicant Signature

Dated at _____, California
City

Date **TODAY'S DATE**
MM/DD/YYYY

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS IS A PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendant(s) named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney's fee will be set by the Workers' Compensation Appeals Board at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

For "amended" applications, the venue choice must be the same as that specified on the original application, unless an order changing venue has issued. A street or P.O. Box address within the United States must be entered for the place where the injury occurred. Therefore, if the injury did not occur at a fixed or identifiable location (such as a field, a highway, or on water), or if the injury occurred outside of the United States, the employer's business address or another appropriate address must be specified; however, a short explanation regarding the place of injury may be appended to the application. If medical treatment has been paid for by Medi-Cal, Medicare, group health insurance, or a private carrier, please specify.

Service of Documents

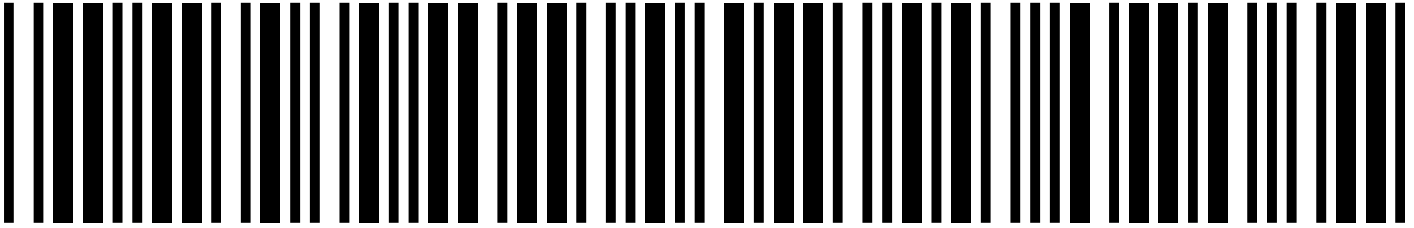
Your attorney or agent will serve all documents in accordance with Labor Code section 5501 and the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file a Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the district office of the Workers' Compensation Appeals Board, or by calling the district office and requesting this form.

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

Document Type

Document Title

Document Date
MM/DD/YYYY

Author

Office Use Only

Received Date _____
MM/DD/YYYY



Proof of Service by Mail

I declare that:

I am (resident of / employed in) the county of YOUR COUNTY, California.

I am over the age of eighteen years, my (business / residence) address is:

PUT YOUR HOME ADDRESS HERE

On TODAY'S DATE, I served the attached NAME OF DOCUMENT

on the parties listed below in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at

CITY WHERE YOU MAILED THIS addressed as follows:

- 1) WORKERS' COMPENSATION APPEALS BOARD: ADDRESS
- 2) INSURANCE COMPANY: NAME, ADDRESS AND CLAIM NUMBER
- 3) DEFENSE ATTORNEY (IF KNOWN): NAME AND ADDRESS
- 4) ALL OTHER PARTIES INVOLVED IN YOUR CASE: NAME AND ADDRESS

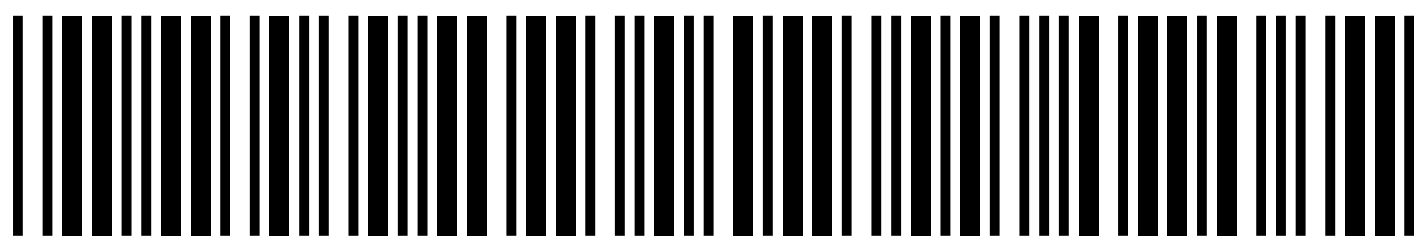
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) TODAY'S DATE, at CITY, California.

Type or print name PRINT YOUR NAME

Signature SIGN YOUR NAME

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

Document Type

Document Title

Document Date
MM/DD/YYYY

Author

Office Use Only

Received Date _____
MM/DD/YYYY



DECLARATION PURSUANT TO LABOR CODE SECTION 4906(h)

Pursuant to Labor Code Section 4906(h), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Date: **TODAY'S DATE**

 YOUR SIGNATURE
Signature

Before signing this form, you should be aware that: “Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers’ compensation benefits or payments is guilty of a felony.”