



**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



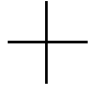
**Employer #4 Information (Completion of this section is required)**

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:

Empty rectangular box for medical-legal expenses and/or liens.

6. Applicant's attorney requests a fee of \$ \_\_\_\_\_

Fees to be commuted as follows:

Empty rectangular box for commuted fees.

7. Liens Against compensation are payable as follows:

Empty rectangular box for liens against compensation.



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

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**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

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**Interpreter License Number:**

\_\_\_\_\_  
Interpreter Name

\_\_\_\_\_  
Interpreter License Number

