

DWC-WCAB form 10214 (a) -1 Page 1 (Rev 5/2020)

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

		Date of Injury		
Case No.			MM/DD/YYYY	
SSN (Numbers On	ly)			
Venue Choice is b	ased upon: (Completion of t	his section is required)		
County of reside	ence of employee (Labor Code	e section 5501.5(a)(1) or (d).)		
County where in	njury occurred (Labor Code se	ction 5501.5(a)(2) or (d).)		
County of princi	ipal place of business of emplo	oyee's attorney (Labor Code section	5501.5(a)(3) or (d	d).)
			,,,,,	,,
Select 3 Letter Office	ce Code For Place/Venue of H	earing (From the Document Cover S	Sheet)	
Applicant (Comple	etion of this section is requir	ed)		
First Name			MI	
Last Name			_	
Address/PO Box (F	Please leave blank spaces bet	ween numbers, names or words)		
(	'	,		
City			State	Zip Code
Employer #1 Infor	mation (Completion of this s	ection is required)		
Insured	Self-Insured	Legally Uninsured	Uninsu	ured
	_			
Employer Name (P	lease leave blank spaces betv	veen numbers, names or words)		
	·	•		
Employer Street Ad	ddress/PO Box (Please leave l	olank spaces between numbers, nar	nes or words)	
, ,	· ·	·	,	
City			 State	Zip Code
Oity			Glate	Zip Gode

urance Carrier Name (Please leave blank spaces between numbers, names or wo	rds)	
surance Carrier Street Address/PO Box (Please leave blank spaces between numb	ers, names or words)	
ty	State	Zip Code
aims Administrator Information (if known and if applicable)		
ame (Please leave blank spaces between numbers, names or words)		
treet Address/PO Box (Please leave blank spaces between numbers, names or wor	rds)	
tity	State	Zip Code
mployer #2 Information (Completion of this section is required)		
Insured Self-Insured Legally Uninsured	Unins	ured
Employer Name (Please leave blank spaces between numbers, names or wo	ords)	
Employer Street Address/PO Box (Please leave blank spaces between numb	pers, names or words)	
	pers, names or words)  State	Zip Code
Employer Street Address/PO Box (Please leave blank spaces between numb  City  nsurance Carrier Information if known and if applicable - include even if carrier is adjusted by claims	State	Zip Code
City nsurance Carrier Information f known and if applicable - include even if carrier is adjusted by claims	State administrator)	Zip Code
City nsurance Carrier Information	State  administrator)	Zip Code

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

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
mployer #3 Information (Completion of this section is required)		
Insured Self-Insured Legally Uninsured	Unins	ured
Employer Name (Please leave blank spaces between numbers, names or words)		
Employer Street Address/PO Box (Please leave blank spaces between numbers, names o	or words)	
City	State	Zip Code
nsurance Carrier Name (Please leave blank spaces between numbers, names or words)		
nsurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or	words)	
	words)  State	Zip Code
City		Zip Code
City Claims Administrator Information (if known and if applicable)		Zip Code
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or City  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)		Zip Code
Claims Administrator Information (if known and if applicable)  Name (Please leave blank spaces between numbers, names or words)		Zip Code  Zip Code

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Employer #4 Inforr	mation (Completion of this s	section is required)			
Insured	Self-Insured	Legally Uninsured	Unins	sured –	
Employer Name (P	lease leave blank spaces bet	ween numbers, names or words)			
Employer Street Ac	ddress/PO Box (Please leave	blank spaces between numbers, na	nmes or words)		
City Insurance Carrier I (if known and if ap		rrier is adjusted by claims admin	State	Zip Code	
Insurance Carrier Nai	me (Please leave blank spaces b	petween numbers, names or words)			
Insurance Carrier Stre	eet Address/PO Box (Please lea	ve blank spaces between numbers, nan	nes or words)		
City Claims Administra	tor Information (if known ar	nd if applicable)	State	Zip Code	
Name (Please leave l	blank spaces between numbers,	names or words)			
Street Address/PO Bo	ox (Please leave blank spaces be	etween numbers, names or words)			
City			State	Zip Code	
requirements of Lab	oor Code section 5313:	Award and/or Order, based upon the	ne following facts	, and waive the -	
Employees Last	Name		,		
birth date	MM/DD/YYYY	- ,			
while employed at	·			,	State
as a(n)		Occupation		, Group	in
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ion Cases	1
Specific 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)
Body Part 2:	Body Part 3:
Other Body Parts:	
Specific 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)
Body Part 2:	Body Part 3:
Other Body Parts:	
Specific 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)
Body Part 2:	Body Part 3:
Other Body Parts:	
Specific 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)
Body Part 2:	Body Part 3:
Other Body Parts:	
	ustained injury(ies) arising out of and in the course of employme
(Please list all	body parts injured)
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	Specific Injury  Cumulative Injury  Body Part 2:  Other Body Parts:  Specific Injury  Body Part 2:  Other Body Parts:  Specific Injury  Cumulative Injury  Body Part 2:  Other Body Parts:  Specific Injury  Cumulative Injury  Body Part 2:  Other Body Parts:  Specific Injury  Cumulative Injury  Other Body Parts:  Specific Injury  Cumulative Injury  Body Part 2:  Other Body Parts:  eir insurer(s) listed above and who set

2. The injury (ies) caused temporary disability for the period	through
for which indemnity has bee	n paid at \$ per week.
MM/DD/YYYY	Indemnity Paid
2(a). The injury(ies) caused additional temporary disability for the	period
through at the rate of \$	Rate in the amount of \$ Indemnity Paid
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
previously made. And a life pension of \$	_ per week thereafter.
An informal rating has / has not (Select one) been prev	riously 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 defendan	t as follows:
6. Applicant's attorney requests a fee of \$	
Fees to be commuted as follows:	
7. Liens Against compensation are payable as follows:	

9.Other stipulations:			
Dated	Applicant		
ו ו ז ז לטטווווווווווווווווווווווווווווו	Applicant		
Applicant's Attorney or Authorized Representative:			1
Law Firm/Attorney Non Attorney Representative			+
First Name			
T list Numb			
Last Name			
Firm Number			
Timited			
Law Firm name			
Address/PO Box (Please leave blank spaces between numbers, names or words)		-	
City	 State	Zip Code	
Dated	Applicant Attorney Sig	ınature	
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8. Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
			$\perp$
E. AN			
First Name			
Last Name			
Last Name			
Firm Number			
Law Firm Name			
Address/PO Box (Please leave blank spaces between numbers, names or words)			
Address/FO Box (Flease leave blank spaces between numbers, names or words)			
O't.		<del></del>	
City	State	Zip Code	
2-4-4			
DatedMM/DD/YYYY	D 6		
	Defense Attorney	Signature	
Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
First Name			
, not realise			
Last Name			
Last Name			
Firm Number			
Law Firm Name			
Address/PO Box (Please leave blank spaces between numbers, names or words)			
City			
	State	Zip Code	
	State	Zip Code	
Dated	State	Zip Code	
Dated			
Dated	State  Defense Attorne		

Dolollaulit o 7 titollioy of	Authorized Representative:			
Law Firm/Attorney	Non Attorney Representative			4
				ı
First Name				
Last Name				
Firm Number				
i iiii Numbei				
Law Firm Name				
Law i iiii ivanie				
Address/PO Box (Please lea	ave blank spaces between numbers, names or word	s)		
Address/PO Box (Please lea	ave blank spaces between numbers, names or word	s)		
Address/PO Box (Please lea	ave blank spaces between numbers, names or word	s) State	Zip Code	
	ave blank spaces between numbers, names or word		Zip Code	
		State		
City				
City  DatedMM/DD/	/YYYY ——	State		
City	/YYYY ——	State		
City  DatedMM/DD/	YYYYY	State	Signature	