

DWC-CA form 10214 (a) Page 1 (Rev 11/2008)

## 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   | ection 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 | ).)      |
| 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 | red)                                |                    |          |
| 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 Inform     | mation (Completion of this s    | ection is required)                 |                    |          |
| Insured                | Self-Insured                    | Legally Uninsured                   | Uninsu             | red      |
| Employer Name (P       | Please leave blank spaces betw  | ween numbers, names or words)       |                    |          |
| Employer Street Ac     | ddress/PO Box (Please leave I   | blank spaces between numbers, nan   | nes or words)      | _        |
| City                   |                                 |                                     | State              | Zip Code |
|                        |                                 |                                     |                    |          |

| surance Carrier Name (Please leave blank spaces between numbers, names or words)   |                |          |
|--|----------------|----------|
| nsurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, nar   | mes or words)  |          |
| Dity   | State          | Zip Code |
| laims Administrator Information (if known and if applicable)   |                |          |
| lame (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 #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 words)  |                |          |
| Employer Street Address/PO Box (Please leave blank spaces between numbers, na  | ames or words) |          |
| City   | State          | Zip Code |
| nsurance Carrier Information<br>if known and if applicable - include even if carrier is adjusted by claims admin   | nistrator)     |          |
| Ourien Name (Diagram la control de la contro |                |          |
| Insurance Carrier Name (Please leave blank spaces between numbers, names or words)   |                |          |
|  |                |          |
| Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, nar  | mes or words)  |          |

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

| 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 |
| 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 of         | 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)    |          |
| 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 |
| <del> </del>  |           | ı        |

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| Employer #4 Inform                                 | 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 Ad                                 | ddress/PO Box (Please leave      | blank spaces between numbers, na     | ames or words)     |                 |       |
| City<br>Insurance Carrier I<br>(if known and if ap |                                  | rrier is adjusted by claims admin    | State              | Zip Code        |       |
| Insurance Carrier Nar                              | me (Please leave blank spaces b  | netween numbers, names or words)     |                    |                 |       |
| Insurance Carrier Stre                             | eet Address/PO Box (Please leav  | ve blank spaces between numbers, nan | nes or words)      |                 |       |
| City<br>Claims Administra                          | tor Information (if known ar     | nd if applicable)                    | State              | Zip Code        |       |
| Name (Please leave b                               | 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 th    | 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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| Body Part 1: Body Part 2: Body Part 3:   Other Body Parts:   Specific Injury   (End Date: MM/DD/YYYY)   (End Date: MM/D | More than 4 Compa       | inion Cases       | I   |
|--|-------------------------|-------------------|---|
| Body Part 2: Body Part 3:   Specific Injury   Start Date: MM/DD/YYYY   (End Date: MM/DD/YYYY)   (End Date: MM/DD/YYYY)  |                         | Specific Injury   | _   |
| Specific Injury  ase Number 2  | ase Number 1            | Cumulative Injury |   |
| Specific Injury  ase Number 2  Cumulative Injury  (Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as the specific date of injury)  ody Part 1:  Body Part 2:  Specific Injury  ase Number 3  Cumulative Injury  (Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as the specific date of injury)  ody Part 1:  Body Part 2:  Body Part 3:  Other Body Part 2:  Body Part 3:  Other Body Parts:  Specific Injury  ase Number 4  Cumulative Injury  (Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as the specific date of injury)  (Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as the specific date of injury)  ase Number 4  Cumulative Injury  Other Body Part 2:  Body Part 3:  Other Body Part 2:  Body Part 3:  Other Body Part 2:  Body Part 3:  Other Body Part 3:   | ody Part 1:             | Body Part 2:      | Body Part 3:  |
| ase Number 2  Cumulative Injury  (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)  ody Part 1:  Body Part 2:  Body Part 3:  Other Body Parts:  Specific Injury  ase Number 3  Cumulative Injury  (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)  ody Part 1:  Body Part 2:  Body Part 3:  Other Body Part 2:  Body Part 3:  Other Body Parts:  Specific Injury  ase Number 4  Cumulative Injury  (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)  ody Part 4:  Specific Injury  Specific Injury  Specific Injury, use the start date as the specific date of injury)  ody Part 4:  Other Body Part 2:  Body Part 3:  Ody Part 4:  Other Body Part 2:  Body Part 3:  Other Body Part 3:  | ody Part 4:             | Other Body Parts: |   |
| Body Part 2:   Body Part 3:  |                         | Specific Injury   |   |
| Other Body Parts:  Specific Injury  ase Number 3  Cumulative Injury  Specific Injury  (Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as the specific date of injury)  ody Part 1:  Body Part 2:  Specific Injury  Specific Injury  Specific Injury  (Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as the specific date of injury)  ody Part 4:  Specific Injury  (Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as the specific date of injury)  ody Part 1:  Body Part 2:  Body Part 3:  Ody Part 4:  Other Body Part 2:  Body Part 3:  Ody Part 4:  Other Body Parts:  | ase Number 2            | Cumulative Injury |   |
| Specific Injury    Specific Injury   Start Date: MM/DD/YYYY)   (End Date: MM/DD/YYYY)  | ody Part 1:             | Body Part 2:      | Body Part 3:  |
| ase Number 3  Cumulative Injury  (Start Date: MM//DD/YYYY)  (If Specific Injury, use the start date as the specific date of injury)  Dody Part 1:  Body Part 2:  Dother Body Parts:  Specific Injury  (Start Date: MM//DD/YYYY)  (End Date: MM//DD/YYYY)  (If Specific Injury, use the start date as the specific date of injury)  Dody Part 4:  Body Part 2:  Body Part 3:  Specific Injury, use the start date as the specific date of injury)  Dody Part 1:  Body Part 2:  Body Part 3:  Dody Part 4:  Other Body Parts:  | ody Part 4:             | Other Body Parts: |   |
| ody Part 1: Body Part 2: Body Part 3:  Other Body Parts:  Specific Injury  ase 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)  ody Part 1: Body Part 2: Body Part 3:   |                         | Specific Injury   |   |
| Other Body Parts:  Specific Injury  ase Number 4  Cumulative Injury  (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)  ody Part 1:  Body Part 2:  Body Part 3:  Other Body Parts:  | ase 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) |
| Specific Injury  ase Number 4  Cumulative Injury  (Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as the specific date of injury)  ody Part 1:  Body Part 2:  Other Body Parts:  | ody Part 1:             | Body Part 2:      | Body Part 3:  |
| ase Number 4 Cumulative Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)  ody Part 1: Body Part 2: Body Part 3:  ody Part 4: Other Body Parts:  | ody Part 4:             | Other Body Parts: |   |
| ody Part 1: Body Part 2: Body Part 3: body Part 4: Other Body Parts:   |                         | Specific Injury   |   |
| ody Part 4: Other Body Parts:  | ase 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) |
|  | ody Part 1:             | Body Part 2:      | Body Part 3:  |
|  | ody Part 4:             | Other Body Parts: |   |
|  | the employer(s) and the |                   |   |
|  |                         |                   |   |
|  |                         |                   |   |
|  |                         |                   |   |
|  |                         | (Please list all  | body parts injured)   |

| 2. The injury (ies) caused temporary disability for the per  | iod through   |
|--|---|
| for which indemnity  | has been haid at \$                                       |
| MM/DD/YYYY   | has been paid at \$ per week                              |
| 2(a). The injury(ies) caused additional temporary disability | y for the period  |
| through at the rate o  | f \$ 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.                                      |
| Labor Code §4658(d) adjustment:                              |   |
| Increase rate to \$ as of                                    |   |
|  | MM/DD/YYYY  |
| Decrease rate to \$ as of                                    |   |
| as or  | MM/DD/YYYY  |
| Not Applicable   |   |
|  |   |
| An informal rating has / has not (Select one) be             | een 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 do     | efendant as follows:                                      |
|  |   |
|  |   |
|  |   |
| 6. Applicant's attorney requests a fee of \$                 |   |
| Fees to be commuted as follows:                              |   |
|  |   |
|  |   |
|  |   |
| 7. Liens Against compensation are payable as follows:        |   |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |
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| 9.Other stipulations:  |                        |          |   |
|--|------------------------|----------|---|
|  |                        |          |   |
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|  |                        |          |   |
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|  |                        |          |   |
| $\top$   |                        |          |   |
| Dated  | Applicant              |          |   |
|  | , привани              |          |   |
| Applicant's Attorney or Authorized Representative:                         |                        |          | ı |
| 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  | Applicant Attorney Sig | nature   |   |
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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                                |                        |           |             |
|  |                        |           |             |
| First Name   |                        |           |             |
| First Name   |                        |           |             |
|  |                        |           |             |
| Last Name  |                        |           |             |
| Lastinanie   |                        |           |             |
|  |                        |           |             |
| Firm Number  |                        |           |             |
|  |                        |           |             |
|  |                        |           |             |
| Law Firm Name  |                        |           |             |
|  |                        |           |             |
| Address/PO Box (Please leave blank spaces between numbers, names or words)   |                        |           |             |
| Address/1 & Box (1 lease leave blank spaces between numbers, names of words) |                        |           |             |
|  |                        |           |             |
| City   | <br>State              | Zip Code  |             |
| Oity   | State                  | Zip Code  |             |
| Dated  |                        |           |             |
| MM/DD/YYYY ———   | Defense Attorney       | Signature |             |
| Defendantle Attenness on Asith original Department files                     | Delense Automey        | 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  |             |
|  | State                  | Zip Code  |             |
| City  Dated  MM/DD/YYYY  | State                  | Zip Code  |             |
| Dated  |                        |           |             |
| Dated  | State  Defense Attorne |           | —<br>—<br>— |

| 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 lea | ave blank spaces between numbers, names or word: | s)               |             |  |
| `                          | ,  | ,                |             |  |
|                            |  |                  |             |  |
| City                       |  | State            | Zip Code    |  |
|                            |  |                  |             |  |
| DatedMM/DD/\               |  |                  |             |  |
| IVIIVI/DD/                 | 1111   | Defense Attorney | Signature   |  |
|                            |  |                  |             |  |
| Interpreter Licence Num    | ber:   |                  |             |  |
|                            |  |                  |             |  |
|                            |  |                  |             |  |
| Interpreter Nar            | me   | Interpreter Lice | ense Number |  |
|                            |  |                  |             |  |
|                            |  |                  |             |  |