

Cómo presentar un embargo preventivo

El presentar una notificación y solicitud para la concesión de un embargo preventivo es la forma de hacer un reclamo para el pago monetario que se le debe en un caso de compensación de trabajadores.

Un formulario de embargo preventivo se encuentra adjunto. Llene el formulario. Asegúrese de firmarlo y fecharlo. Este formulario también se puede completar en <http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCForm6.pdf>.

Un número de caso de la Junta de Apelaciones de Compensación de Trabajadores (*Workers' Compensation Appeals Board- WCAB*) debe ser puesto en la esquina derecha de la parte superior del embargo preventivo. Si no hay un número de caso en la *WCAB*, comuníquese con la oficina local de Información y Asistencia (*Information & Assistance- I&A*).

Envíe el original a su oficina local de la *WCAB* y copias a todas las partes.

Presente los siguientes documentos con su formulario en el orden indicado:

- ✓ [Hoja de Portada de Documento](#)
- ✓ [Hoja de Separador de Documento](#) (para la Notificación y Solicitud Para la Concesión de un Embargo Preventivo)
- ✓ [Notice and Request for Allowance of Lien](#) (Notificación y Solicitud Para la Concesión de un Embargo Preventivo)
- ✓ [Hoja de Separador de Documento](#) (para la Verificación 10770.5)
- ✓ [Lien Verification 10770.5](#) (Verificación 10770.5)
- ✓ [Hoja de Separador de Documento](#) (para la Prueba de Entrega por Correo)
- ✓ [Proof of Service by Mail](#) (Prueba de Entrega por Correo)

Hay límites de tiempo para presentar embargos preventivos para los proveedores médicos y las personas solicitantes de embargos preventivos médico-legales. También estas partes están limitadas a presentar sus peticiones electrónicamente, ya sea por *jet filing* o *e-filing*. Dichos embargos preventivos deben presentarse:

1. Para servicios proporcionados antes del 1 de julio de 2013, dentro de tres años de la fecha en que los últimos servicios fueron proporcionados.
2. Para servicios proporcionados después del 1 de julio de 2013, dentro de 18 meses de la fecha en que los últimos servicios fueron proporcionados.

Guarde copias de sus documentos presentados para su archivo.

Guía 10 de la Unidad de Información y Asistencia

Todos los documentos presentados en la *WCAB* deben incluir una hoja de portada de documento y una hoja de separador de documento. Por favor consulte las guías 17 y 18 de *I&A* para aprender cómo llenar estos formularios. Además todos los formularios deben ser escritos a máquina o a mano utilizando letra de molde para asegurar la legibilidad. Instrucciones de formularios adicionales pueden ser encontradas en el manual de formularios *OCR* de *EAMS* en http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf.

Si necesita ayuda, llame a una [oficina de Información y Asistencia \(I&A\)](#) o asista a un [taller para trabajadores lesionados](#). Los números de teléfono de las oficinas locales de *I&A* están adjunto a esta guía. Usted puede obtener información sobre un taller local de la oficina de *I&A* o en la Web en www.dwc.ca.gov.

Si no tiene el nombre y la dirección de su administrador de reclamos para completar un formulario, por favor enlace a <http://www.dir.ca.gov/DWC/EAMS/EAMS-LC/EAMSClaimsAdmins.asp>.

La información contenida en esta guía es de índole general y no pretende substituir asesoramiento legal. Los cambios en la ley o los datos específicos de su caso podrían resultar en interpretaciones legales distintas de las que aquí se presentan.

Al enviar documentos a una oficina regional, por favor asegúrese que no estén doblados ni estén engrapados. Envíelos en un sobre grande de manila. Por favor consulte con el manual de formularios *OCR* de *EAMS* para instrucciones adicionales.

WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

ANAHEIM, 92806-2131

1065 N PacificCenter Drive, Suite 170
Information & Assistance Unit (714) 414-1800

BAKERSFIELD, 93301-1929

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

EUREKA, 95501-0481 * Satellite office *

100 "H" Street, Suite 202
Information & Assistance Unit (707) 441-5723

FRESNO, 93721-2219

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

LONG BEACH, 90802-4339

300 OceanGate Street, Suite 200
Information & Assistance Unit (562) 590-5240

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) 482-3858

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 Fl, Ste. 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, 95113-1402

100 Paseo de San Antonio, Suite 241
Information & Assistance Unit (408) 277-1292

SAN LUIS OBISPO, 93401-8736

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

SANTA ANA, 92701-4070

605 W Santa Ana Boulevard, Bldg 28, Suite 451
Information & Assistance Unit (714) 558-4597

SANTA BARBARA, 93101-7538 * Satellite office *

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

SANTA ROSA, 95404-4771

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

STOCKTON, 95202-2314

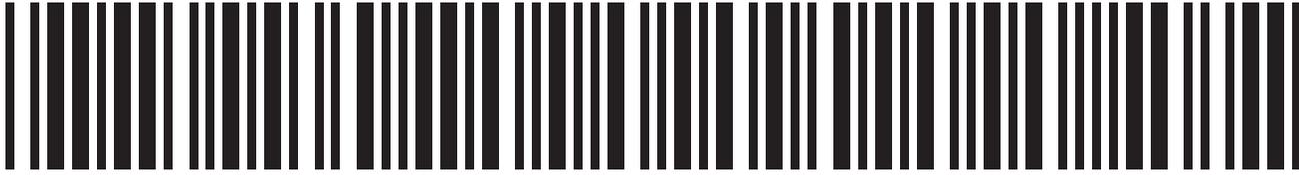
31 E Channel Street, Suite 344
Information & Assistance Unit (209) 948-7980

VAN NUYS, 91401-3370

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

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET



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

More than 15 Companion Cases

Date:(MM/DD/YYYY)

SSN: _____

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 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

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

ADJ DEU SIF UEF 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: _____

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 3: _____

Body Part 2: _____

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 3: _____



Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Specific Injury

Case Number 5

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: _____



Specific Injury

Case Number 6

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: _____

Specific Injury

Case Number 7

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: _____

Specific Injury

Case Number 8

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: _____



Specific Injury

Case Number 9

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: _____

Specific Injury

Case Number 10

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: _____

Specific Injury

Case Number 11

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: _____



Specific Injury

Case Number 12

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: _____

Specific Injury

Case Number 13

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: _____

Specific Injury

Case Number 14

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: _____



Specific Injury

Case Number 15

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: _____



Specific Injury

Case Number 16

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

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

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

Body Part Code List

The body part codes listed below are used to complete forms that require the listing of the part of the body that is in issue. Please do not file this document with your forms.

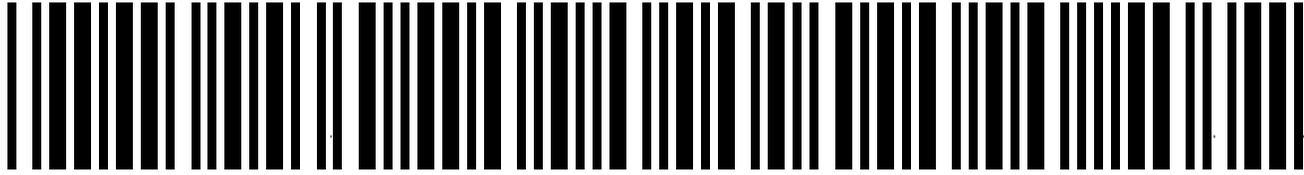
100	Head - not specified	500	Lower extremities - not specified
110	Brain	510	Legs - above ankles, not specified
120	Ear - not specified	511	Thigh femur
121	Ear - external	513	Knee Patella
124	Ear - internal including hearing	515	Lower leg tibia and fibula
130	Eye - including optic nerves and vision	518	Leg - multiple parts any combination of above parts
140	Face - not specified	519	Leg - not specified
141	Jaw - including chin and mandible	520	Ankle malleolus
144	Mouth - including lips, tongue, throat and taste	530	Foot not ankle or toe
145	Teeth	540	Toes
146	Nose - including nasal passages, sinus and smell	598	Lower extremities - multiple parts any combination of above parts
148	Face - 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
149	Face - forehead, cheeks, eyelids	800	Body system - not specific
150	Scalp	801	Circulatory system - heart -other than heart attack, blood, arteries, veins, etc.
160	Skull	802	Circulatory system - Heart attack
198	Head - multiple injury any combination of above parts	810	Digestive system - stomach
200	Neck	820	Excretory system - kidneys, bladder, intestines, etc
300	Upper extremities - not specified	830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
310	Arm - above wrist not specified	840	Nervous system - not specified
311	Arm - upper arm humerus	841	Nervous system - stress
313	Arm - elbow head of radius	842	Nervous system - Psychiatric/psych
315	Arm -forearm radius and ulna	850	Respiratory system - lungs, trachea, etc.
318	Arm - multiple parts any combination of above parts	860	Skin dermatitis, etc.
319	Arm - not specified	870	Reproductive systems
320	Wrist	880	Other body systems
330	Hand - not wrist or fingers	999	Unclassified - insufficient information to identify body parts
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		

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

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

EJEMPLO

DOCUMENT COVER SHEET



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

More than 15 Companion Cases

FECHA DE HOY

Date:(MM/DD/YYYY)

SSN:

SU NÚMERO DE SEGURO SOCIAL

Specific Injury

Cumulative Injury

FECHA DE LA LESIÓN

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

NÚMERO DE CASO EAMS

Case Number 1

SI ES UN CASO NUEVO DEJE EN BLANCO

Body Part 1:

UTILICE UN CÓDIGO DE LAS LISTA DE CÓDIGOS DE LAS PARTES DEL CUERPO, CONSULTE LA P.8

Body Part 3:

Body Part 2:

Body Part 4:

Other Body Parts:

Please check unit to be filed on (check only one box) MARQUE LA CASILLA DE LA UNIDAD APROPIADA

ADJ DEU SIF UEF INT RSU

Companion Cases CASOS COMPAÑEROS

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:

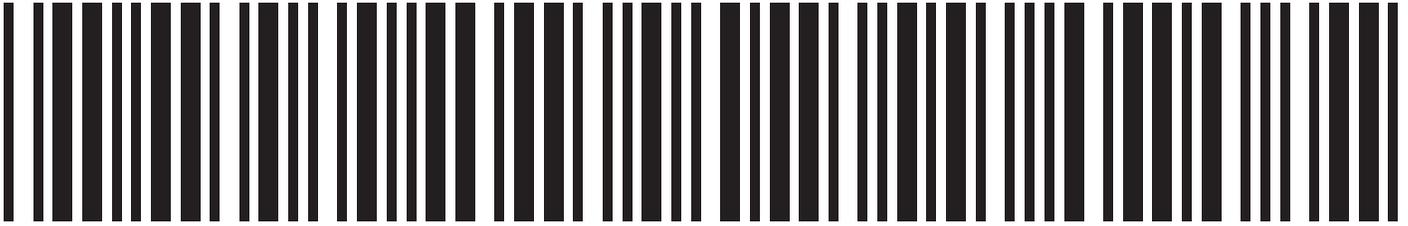
Body Part 3:

Body Part 2:

Body Part 4:

Other Body Parts:

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

Document Type

Document Title

Document Date

MM/DD/YYYY

Author

Office Use Only

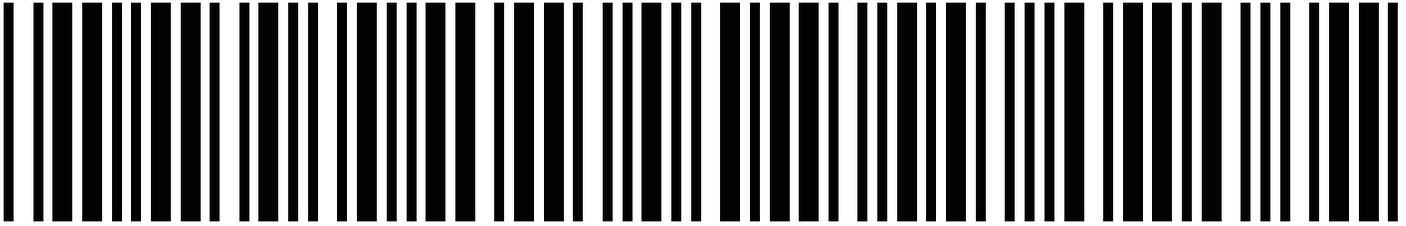
Received Date

MM/DD/YYYY



DOCUMENT SEPARATOR SHEET

EJEMPLO



Product Delivery Unit

ADJ

Document Type

LIENS AND BILLS

Document Title

NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Document Date

FECHA EN QUE LLENÓ EL FORMULARIO

MM/DD/YYYY

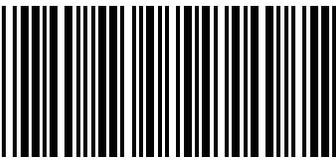
Author

SU NOMBRE

Office Use Only

Received Date

MM/DD/YYYY



**STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN**



Date Of Original Lien: _____
MM/DD/YYYY

Original Lien

Amended Lien

Case No. _____

(Choose only one)

a specific injury on _____
(DATE OF INJURY: MM/DD/YYYY)

a cumulative injury which began on _____ and ended on _____
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

SSN (Numbers Only) _____

(DATE OF BIRTH: MM/DD/YYYY)

Injured Worker:

First Name _____

MI

Last Name _____

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

City _____

State

Zip Code

Attorney/Representative for Injured Worker:

Name _____

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

City _____

State

Zip Code

Lien Claimant (Completion of this section is required):

Name of Organization filing lien (for individual lien claimants, leave blank) _____

First Name of Individual filing lien(organizational lien claimants, leave blank) _____

Last Name of Individual filing lien(organizational lien claimants, leave blank) _____

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

City _____

State

Zip Code

Phone _____



Lien Claimant's Attorney/Representative, if any

Law Firm/Attorney

Non-Attorney Representative

Lien Claimant not represented



Lien Claimant Law Firm/Representative

First Name

Last Name

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

City

State

Zip Code

Phone

Employer

Name

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

City

State

Zip Code

Insurance Carrier or Claims Administrator

Name

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

City

State

Zip Code

Employer or Claims Administrator Attorney/Representative (if known)

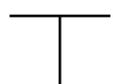
Name

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

City

State

Zip Code



The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of \$ _____ against any amount now due or which may hereafter become payable as compensation to the above-named employee on account of the above-claimed injury.

Total Lien Amount

This request and claim for lien is for (mark appropriate box):

- A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).)
- Reasonable expense incurred by or on behalf of the injured employee for medical-legal expenses. (Labor Code § 4903 (b).)
- The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)
- The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- The reasonable fee for interpreter's services performed on _____ 20 ____ . (Labor Code § 4600 (f).)
- The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)
- Other Lien(s): Specify nature and statutory basis.

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

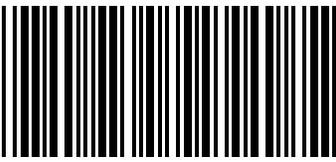
- A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

(Signature of Attorney/Representative for Lien Claimant)

(Signature of Lien Claimant)

Date (MM/DD/YYYY)





**STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN**

EJEMPLO

Date Of Original Lien: _____
MM/DD/YYYY

Original Lien

Amended Lien

NÚMERO DE CASO DE EAMS

Case No. _____

(Choose only one)

a specific injury on **FECHA DE LA LESIÓN**
(DATE OF INJURY: MM/DD/YYYY)

a cumulative injury which began on _____ and ended on _____
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

NÚMERO DE SEGURO SOCIAL DEL EMPLEADO LESIONADO

SSN (Numbers Only) _____

FECHA DE NACIMIENTO DEL EMPLEADO LESIONADO

(DATE OF BIRTH: MM/DD/YYYY)

Injured Worker:

PRIMER NOMBRE DEL EMPLEADO LESIONADO

First Name _____ MI

APPELLIDO DEL EMPLEADO LESIONADO

Last Name _____

DOMICILIO DEL EMPLEADO LESIONADO

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

CIUDAD DEL EMPLEADO LESIONADO

City _____

ESTADO

State

CÓDIGO POSTAL

Zip Code

Attorney/Representative for Injured Worker:

NOMBRE DEL ABOGADO DEL EMPLEADO LESIONADO

Name _____

DOMICILIO DEL ABOGADO

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

CIUDAD DEL ABOGADO

City _____

ESTADO

State

CÓDIGO POSTAL

Zip Code

Lien Claimant (Completion of this section is required):

NOMBRE DE LA ORGANIZACIÓN PRESENTANDO LA SOLICITUD PARA LA CONCESIÓN DE UN EMBARGO PREVENTIVO (PARA PERSONAS INDIVIDUALES DEJE EN BLANCO)

Name of Organization filing lien (for individual lien claimants, leave blank)

PRIMER NOMBRE DE LA PERSONA PRESENTANDO ESTA SOLICITUD (SI ES UNA ORGANIZACIÓN DEJE EN BLANCO)

First Name of Individual filing lien(organizational lien claimants, leave blank)

APPELLIDO DE LA PERSONA PRESENTANDO ESTA SOLICITUD (SI ES UNA ORGANIZACIÓN DEJE EN BLANCO)

Last Name of Individual filing lien(organizational lien claimants, leave blank)

DOMICILIO

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

CIUDAD

City _____

ESTADO

State

CÓDIGO POSTAL

Zip Code

NÚMERO DE TELÉFONO

Phone _____
DWC/ WCAB Form 6 (Page 1) Rev(11/2008)

T

Lien Claimant's Attorney/Representative, if any

Law Firm/Attorney Non-Attorney Representative Lien Claimant not represented

NOMBRE DEL ABOGADO O REPRESENTANTE DE LA PERSONA U ORGANIZACIÓN PRESENTANDO ESTA SOLICITUD-USE EL NOMBRE UNIFORME ASIGNADO

Lien Claimant Law Firm/Representative

PRIMER NOMBRE DEL REPRESENTANTE O ABOGADO

First Name

APELLIDO DEL REPRESENTANTE O ABOGADO

Last Name

CÓDIGO POSTAL

DIRECCIÓN DEL REPRESENTANTE O ABOGADO

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

CIUDAD DEL REPRESENTANTE O ABOGADO

City

ESTADO

State

CÓDIGO POSTAL

Zip Code

NÚMERO DE TELÉFONO DEL REPRESENTANTE O ABOGADO

Phone

Employer

NOMBRE DEL EMPLEADOR CON QUIÉN USTED TRABAJABA AL TIEMPO DE LA LESIÓN

Name

DOMICILIO DEL EMPLEADOR

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

CIUDAD DEL EMPLEADOR

City

ESTADO

State

CÓDIGO POSTAL

Zip Code

Insurance Carrier or Claims Administrator

NOMBRE DE LA COMPAÑÍA DE SEGUROS O ADMINISTRADOR DE RECLAMOS-USE EL NOMBRE UNIFORME ASIGNADO

Name

DOMICILIO DE LA COMPAÑÍA DE SEGUROS O ADMINISTRADOR DE RECLAMOS

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

CIUDAD DE LA COMPAÑÍA DE SEGUROS O ADMINISTRADOR DE RECLAMOS

City

ESTADO

State

CÓDIGO POSTAL

Zip Code

Employer or Claims Administrator Attorney/Representative (if known)

ABOGADO DE LA COMPAÑÍA DE SEGUROS O ADMINISTRADOR DE RECLAMOS

Name

DOMICILIO DE LA COMPAÑÍA DE SEGUROS O ADMINISTRADOR DE RECLAMOS

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

CIUDAD DE LA COMPAÑÍA DE SEGUROS O ADMINISTRADOR DE RECLAMOS

City

ESTADO

State

CÓDIGO POSTAL

Zip Code

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of \$ **CANTIDAD DEL EMBARGO PREVENTIVO** against any amount now due or which may hereafter become payable as Total Lien Amount

compensation to the above-named employee on account of the above-claimed injury.

This request and claim for lien is for (mark appropriate box): **SELECCIONE LA RAZÓN POR LA CUAL ESTÁ PRESENTANDO ESTA SOLICITUD**

- A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).)
- Reasonable expense incurred by or on behalf of the injured employee for medical-legal expenses. (Labor Code § 4903 (b).)
- The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)
- The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- The reasonable fee for interpreter's services performed on _____ 20 ____ . (Labor Code § 4600 (f).)
- The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)
- Other Lien(s): Specify nature and statutory basis.

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

FIRMA DEL ABOGADO O REPRESENTANTE DE LA PERSONA PRESENTANDO ESTA SOLICITUD

FIRMA DE LA PERSONA QUE ESTÁ PRESENTANDO ESTA SOLICITUD

FECHA DE HOY

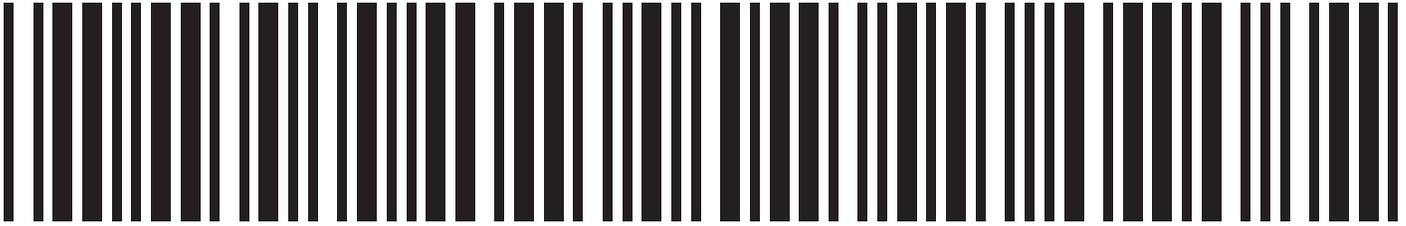
(Signature of Attorney/Representative for Lien Claimant)

(Signature of Lien Claimant)

Date (MM/DD/YYYY)



DOCUMENT SEPARATOR SHEET



Product Delivery Unit

Document Type

Document Title

Document Date

MM/DD/YYYY

Author

Office Use Only

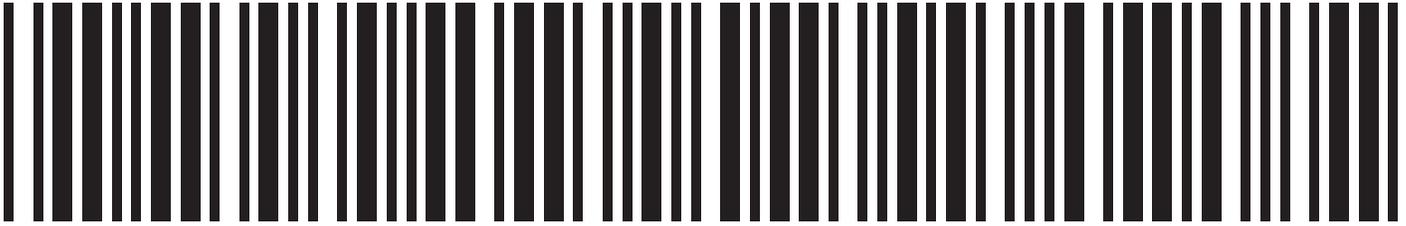
Received Date

MM/DD/YYYY



DOCUMENT SEPARATOR SHEET

EJEMPLO



Product Delivery Unit

ADJ

Document Type

LIENS AND DOCS

Document Title

10770.5 VERIFICATION

Document Date

FECHA EN QUE LLENÓ EL FORMULARIO

MM/DD/YYYY

Author

SU NOMBRE

Office Use Only

Received Date

MM/DD/YYYY

CCR 10770.5 Verification to Filing of Lien Claim

A lien claim is being filed because:

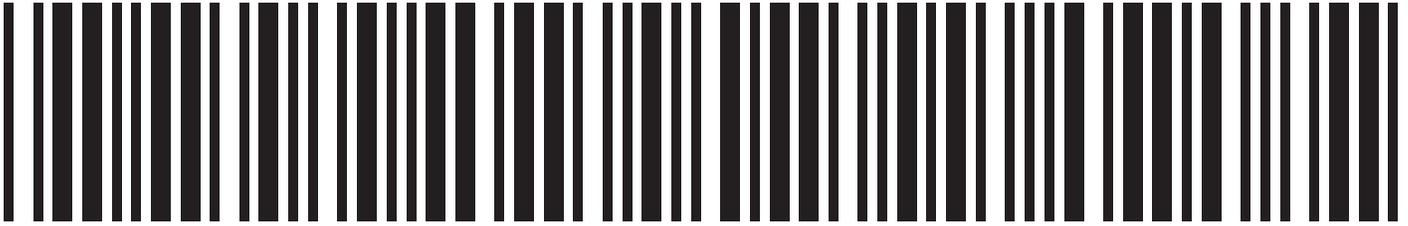
- _____ Sixty days have elapsed since the date of acceptance or rejection of liability for the claim, or the time provided for investigation of liability pursuant of Labor Code Section 5402(b) has elapsed, whichever is earlier.
- _____ The time provided for payment of medical treatment bills pursuant to Labor Code section 4603.2 has elapsed.
- _____ The time provided for payment of medical-legal expenses pursuant to Labor Code section 4622 has elapsed.

I declare under penalty of perjury under the laws of the State of California that one of the time periods set forth in Rule 10770.5(a) has elapsed and, if an application for adjudication is being filed, that venue is proper as set forth in Rule 10770.5(b) and that I have made a diligent search and have determined that no adjudication case number exists for the same injured worker and the same date of injury. In determining that no adjudication case number exists for the same injured worker and the same date of injury, I have made a diligent search consisting of the following efforts (specify):

Signature

Date (MM/DD/YYYY)

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

Document Type

Document Title

Document Date

MM/DD/YYYY

Author

Office Use Only

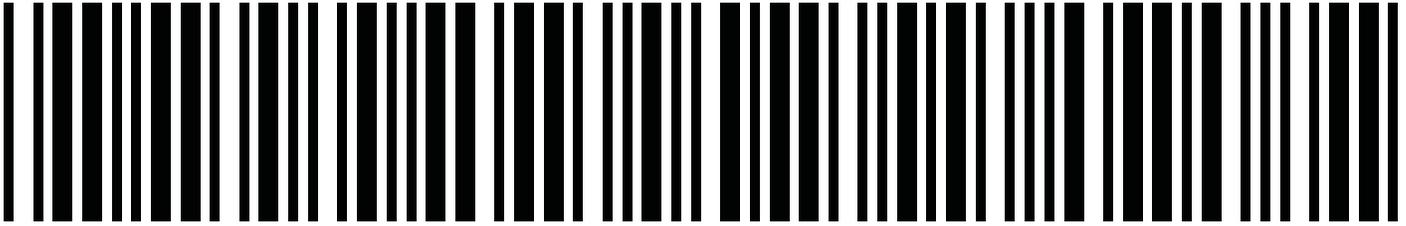
Received Date

MM/DD/YYYY



DOCUMENT SEPARATOR SHEET

EJEMPLO



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

PROOF OF SERVICE

Document Date

FECHA EN QUE LLENÓ EL FORMULARIO

MM/DD/YYYY

Author

SU NOMBRE

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

On _____, I served the attached _____ on the _____ 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

_____ addressed as follows _____

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) _____, at _____ California.

Type or print name _____

Signature _____

Prueba de Entrega por Correo

Yo declaro que:

Soy (residente de/empleado en) el condado de **SU CONDADO** California. Tengo

más de dieciocho años de edad y mi dirección de (negocio/residencia) es:

SU DOMICILIO

El **FECHA DE HOY**, yo entregue el adjunto **EL NOMBRE DEL DOCUMENTO QUE ESTÁ ENVIANDO POR CORREO**

_____ a **NOMBRE DE LAS PARTES A QUIENES LES ESTÁ ENVIANDO EL DOCUMENTO** en dicho caso,

poniendo una copia verdadera del mismo adjunto, en un sobre sellado con el franqueo

completamente pagado, en el correo de los Estados Unidos en **CIUDAD DESDE DONDE ESTÁ ENVIANDO EL DOCUMENTO**

_____ con la siguiente dirección _____

NOMBRE Y DIRECCIÓN DE LA PARTES A QUIENES LES ESTÁ ENVIANDO EL DOCUMENTO

Yo declaro bajo pena de perjurio bajo las leyes del Estado de California que lo siguiente es verdadero y correcto y que esta declaración fue ejecutada en

(fecha) **FECHA DE HOY** en **CIUDAD** California.

Escriba su nombre **ESCRIBA SU NOMBRE CON LETRA DE MOLDE**

Firma **SU FIRMA**
