

STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

INFORMATION RESPONSE FORM

NOTICE: If the injured worker is represented by an attorney, the employer, insurer, or third party administrator shall serve this Information Response Form on the injured worker's attorney within **30 days** of receipt of the Information Request Form.

- 1) Name and address of attorney for employer, insurer or third party administrator:
- 2) Name and address of injured worker:
- 3) Date of claimed injury: _____
Location of injury: _____
- 4) Name and address of employer:
- 5) Name and address of insurer or third party administrator, if any:
- 6) Name, address and phone number of person adjusting claim and claim number:
- 7) Earnings of the employee: _____
- 8) Compensation paid, including (a) total amount, (b) weekly indemnity rate, and (c) date of last payment:

- 9) Medical treatment [has] [has not] been provided.
Date of last treatment: _____

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. Labor Code Section 5401.7.

- 10) The employer denies liability for the following:
- _____ Injury arising out of and occurring in the course of employment.
 - _____ Temporary disability indemnity:
 - _____ Weekly indemnity rate:
 - _____ Period(s) claimed:
 - _____ Other:
 - _____ Permanent disability indemnity
 - _____ Weekly indemnity rate:
 - _____ Nature and extent:
 - _____ Other:
 - _____ Further medical treatment
 - _____ Self-procured medical treatment.
 - _____ Vocation Rehabilitation
 - _____ Vocation Rehabilitation temporary disability indemnity
 - _____ Weekly indemnity rate:
 - _____ Period(s) claimed:
 - _____ Vocation Rehabilitation maintenance allowance
 - _____ Weekly indemnity rate:
 - _____ Period(s) claimed:
 - _____ Other issues:

- 11) Employer [agrees] [does not agree] to arbitration pursuant to part 3.5 (commencing with Labor Code Section 5270).
- 12) Employer [objects] [does not object] to the employee's choice of venue.
- 13) The following medical reports, records and other information are being served with this form:
- 14) Name, address and telephone number of person completing this response form if different than Number 6 above:

NOTICE: The information furnished by the employee in the Information Request Form and the information furnished in the employer's Information Response Form shall not be admissible in any proceeding before the Appeals Board. Item Number 14 on the request form and Item Number 12 on the response form only may be considered in subsequent proceeding involving determinations regarding venue.

Completed by: _____
(Signature)

Date mailed: _____