

GENERAL VALIDATION RULES (PAPER AND EFORM)

1. All dates should be captured as a MM/DD/YYYY format
2. All Dates of Injuries should NOT allow future dates
3. All Dates of Birth should NOT allow future dates
4. All Cumulative Trauma Dates should NOT allow future dates
5. All First Names should be no longer than 25 characters in length
6. All Last Names should be no longer than 25 characters in length
7. All Middle Initials should be no longer than 1 character
8. All Middle Initials are not required fields
9. All Cities should be no longer than 25 characters
10. All State fields should be drop down boxes and use the Curam Lookup Table Fields. The field lengths should be no longer than 10. The Code Value Table in the Holding Tank is: HTCODESTATE. The Fields Lengths on the Paper Forms and The Completion Templates should only allow 2 Characters
11. All Zipcode fields are numeric and should not be longer than 5 characters
12. If Specific Injury is selected, then user is required to enter a Specific Date of Injury. If user does not enter the Specific DOI, then an error message should be displayed.

Dates of Injury Validation ONLY occurs on the Coversheet.

If existing case exists, the the specific date of Injury/CT radio button is now not mandatory (08/15/2008)

13. If Cumulative Trauma (CT) checkbox is selected, then a From Date of Injury and End Date of Injury should be required

If Specific Injury check box is selected, then the From Date of Injury is required

14. Even if fields are not captured for Curam, any date field should have validation rules and should be of the mask: MM/DD/YYYY. A date of February 1st, 2000 should be entered as "02/01/2000"
15. All currency field should be numeric and should not allow alpha characters.
16. All SSN fields are numeric fields and should not allow alpha characters or non-numeric characters. The SSN for EAMS will be read only from the Coversheet and should allow only numeric values. The display to end users in the fillable PDF will be XXX-XX-XXXX. The EAMS OCR application should strip the "-" prior to putting into the Holding Tank
17. If a document is a case initiating document, then if a user types a case number, then field edit check should occur against the case number
18. On the coversheet, if a user selects that it should be filed with an existing case, then case number should be a required field
19. Any Addressline 2 should not be a required fields
20. Any middle initial should not be a required field
21. The international address line should NOT be a required field
22. The state fields should be drop down code values which were provided by Deloitte. When a user selects the two digit state, then we should be putting the corresponding state value into the holding tank. This applies to all the state fields on each of the eforms
23. No validations are required for Claim Numbers and RU Numbers
24. Case Number format on the coversheet will be in the "ALPHA" such as "ADJXXXXXXX" where X are numeric values

25. The bodyparts will be drop downs and will be read from the coversheet. The code value table in the holding tank is: HTCODEBODYPART table

All Body Parts shown as drop downs on the paper forms may display numeric and descriptions, however, all paper forms ready for OCR should only have the numeric values with the description stripped out. The Fillable PDF validation will ensure that this occurs (08/21/08)

All Float fields will be 15 characters in length (including decimals and ","). As per Joel Harter - added 04/23/08

26. All Float Fields on the OCR PDF Documents will be displayed as XXX,XXX.XX

27. All State fields will be two characters in length

28. If legacy case numbers are entered on the paper or eforms, then the validation rules will not apply.

I.E. If user types in "OAKXXXXXX" as a case number, then edit checks will be removed to allow the user to continue to choose the casetype desired

29. All Law Firm Numbers will be 10 characters

Paper Form Comments

BE SURE TO REFER TO PAPER FORM FOR LOCATION OF FIELDS

Should limit to no more than 10 characters in length - most have drop-down calendar

Most have drop-down calendar

EFORM SPECIFIC RULES

1. Checkboxes where at least a single checkbox must be selected should be Radio Buttons
2. All labels should be on the left of the text fields
3. The CT or Specific Dates of Injury Checkboxes must be Radio Buttons
4. Eforms should be able to distinguish a case initiating form vs. existing case. If existing case, then user MUST enter a Case Number

FORM SECTIONS	FAMS FORM FIELD NAMES	Input Criteria (Mandatory M, Optional O, Conditional C)	Data Type	Field Length	Validation Rules	OCR Specifications	Comments
CASE SECTION	Is New Application (Checkbox) (Yes or No)	M	Checkbox	1	IF "New Application" checkbox is selected, then "NEWAPPIND="Y" else the "NEWAPPIND = N". If NEWAPPIND=N, then the CASENUMBER field becomes a required field	There are 2 checkboxes - "Yes" & "No" Only 1 checkbox can be selected	
	Companion Cases Exist (Checkbox) (If Checked, Then cases exist)	M	Checkbox	1	IF "Companion Case Exist" checkbox is selected, then "COMPANIONCASEIND="Y" else "COMPANIONCASEIND="N"		
	Walk-Thru (Checkbox) (Yes/No)		Checkbox	1	This field is only available for the paper form coversheet - those e-forms that fit walk through criteria do have these check boxes	There are 2 checkboxes - "Yes" & "No" Only 1 checkbox can be selected	
	More than 15 Companion Cases (Checkbox)	O	Checkbox	1	If "More than 15 Companion Cases" is checked, then "MORE15COMPANIONCASEIND="Y" else "MORE15COMPANIONCASEIND="N"		
	Date	M	Date	10	MM/DD/YYYY		
	SSN	O	Text	9	Social Security Number is a not required any longer - 07/2008		
	CaseNumber	CM	Text	12	If "NEWAPPIND=N", then this field becomes a required field and user MUST enter a valid case number. Appropriate casenumber validation then applies to this field on case opening form, this is blank - M if you have a case number		
	Specific Injury (Checkbox)	CM	Checkbox	1	If "Specific Injury" checkbox is selected, then "SPECIFICINJURYIND="Y" else "SPECIFICINJURYIND="N" on case opening form, this is M if it is a specific DOI, blank if it is a CT DOI - if you enter a case number above it is blank	Only 1 checkbox can be selected	
	Cumulative Trauma Injury (CT) (Checkbox)	CM	Checkbox	1	If "Cumulative Trauma" checkbox is selected, then "CTIND="Y" else "CTIND="N" on case opening form, this is M if it is a CT DOI, blank if it is a specific DOI - if you enter a case number above it is blank	Only 1 checkbox can be selected	
	Start Date	CM	Date	10	If SPECIFICINJURYIND="Y" or CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field on case opening form, this is M for specific DOI and if a CT enter the beginning date of CT - if you enter a case number above it is blank	MM/DD/YYYY - a CT DOI must have a start date and an ending date	
End Date	CM	Date	10	If CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply on case opening form, this is M if it is a CT DOI enter the ending date of the CT - if you enter a case number above it is blank			
Body Part 1	CM	Text	3	This should be a drop down box with codes and the description. On case opening form, this is M - if you enter a case number above it is blank			
Body Part 2	CM	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down on case opening form, this is M - if you enter a case number above it is blank			
Body Part 3	CM	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down on case opening form, this is M - if you enter a case number above it is blank			
Body Part 4	CM	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down on case opening form, this is M - if you enter a case number above it is blank			
Other Body Parts	CM	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down on case opening form, this is M - if you enter a case number above it is blank			
Venue	Residence of Employee	M	checkbox	4	Fill the text of the checkbox into the VENUE field		
	Location where Injury Occurred	M	checkbox	4	Fill the text of the checkbox into the VENUE field		
	Principal Address of Employees Attorney	M	checkbox	4	Fill the text of the checkbox into the VENUE field		
	3-Digit Office Code	M	Text	3	Fill the text of the checkbox into the VENUE field		
UNIT TO BE FILED ON	ADJ	M	Checkbox	1		Only 1 checkbox can be selected	
	DFU	M	Checkbox	1		Only 1 checkbox can be selected	
	SIF	M	Checkbox	1		Only 1 checkbox can be selected	
	UIFF	M	Checkbox	1		Only 1 checkbox can be selected	
	VOC	M	Checkbox	1		Only 1 checkbox can be selected	
	JNT	M	Checkbox	1		Only 1 checkbox can be selected	
	RSU	M	Checkbox	1	Atleast one casetype radio button/check box must be selected	Only 1 checkbox can be selected	
COMPANION CASE SECTION	Companion Case #1	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field		
	Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected	
	Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected	
	Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field		
	End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply		
	Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field		
	Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down		
	Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down		
Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down			
Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down			

Companion Case #2	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Companion Case #3	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Companion Case #4	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Companion Case #5	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	

	Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Companion Case #6	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
	Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
	End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
	Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
	Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Companion Case #7	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
	Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
	End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
	Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
	Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Companion Case #8	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
	Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
	End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
	Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
	Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Companion Case #9	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
	Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
	End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
	Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
	Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	

	Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Companion Case #10	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
	Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
	End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
	Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
	Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Companion Case #11	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
	Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
	End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
	Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
	Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Companion Case #12	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
	Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
	End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
	Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
	Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Companion Case #13	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
	Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
	End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
	Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
	Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	

	Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Companion Case #14	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
	Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
	End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
	Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
	Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Companion Case #15	O	Text	12	If COMPANIONCASEIND=Y ; then this field is required otherwise this field is not required. If user enters data into this field, then we should capture it and perform the normal validation routine against the casenumber field	
	Specific Injury	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Cumulative Trauma Injury (CT)	O	Checkbox	1	If CC#CASEREFERENCE has data, then CC#SPECIFICINJURYIND or CC#CTIND MUST BE SELECTED	Only 1 checkbox can be selected
	Start Date	O	Date	10	If CC#SPECIFICINJURYIND="Y" or CC#CTIND = Y then "START DATE" is a required field and must have data entered. Appropriate date rules should apply to this field	
	End Date	O	Date	10	If CC#CTIND = Y, then "END DATE" becomes a required field ELSE "END DATE" is not a required field and will not be read. Appropriate date rules and validations should apply	
	Body Part 1	O	Text	3	This should be a drop down box with codes and the description. This is a required field	
	Body Part 2	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 3	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Body Part 4	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	Other Body Parts	O	Text	3	This should be a drop down box with codes and the description. Pick up the body part if the user chose it from the drop down	
	BARCODE VALUE = "COVERSHEET"					

Application for Adjudication							
Legacy Form Field Names	EAMS Form Field Names	Input Criteria (Mandatory M, Optional O, Conditional Mandatory CM)	Data Type	Field Length	Validation Rules	OCR Specifications	Comments
Case Number		CM	Text	12	This will be captured from the coversheet and should be disabled in the eform		
Amended Application		O	Check Box	1	Pick this field up with amended application is checked		
SSN	SSN		numeric	9	This will be captured from the coversheet and should be disabled in the eform		
Venue	Residence of Employee	M	checkbox	1	Fill the text of the checkbox into the VENUE field	Only 1 checkbox can be selected	
	Location where Injury Occurred	M	checkbox	1	Fill the text of the checkbox into the VENUE field	Only 1 checkbox can be selected	
	Principal Address of Employees Attorney	M	checkbox	1	Fill the text of the checkbox into the VENUE field	Only 1 checkbox can be selected	
	3 Digit Office Code	M	Text	3		This is a drop-down list	
Injured Worker Information Section							
Injured Employee's Name	Injured Employee's: First Name	M	Text	25			
	Injured Employee's: Last Name	M	Text	25			
Injured Employee's Address and Zip Code	Injured Employee's: Middle Initial	O	Text	1			
	Injured Employee's: Address	M	Text	40			
	Injured Employee's: Address 2	O	Text	40			
	Injured Employees International Address	O	Text	40			
	Injured Employee's: City	M	Text	25			
	Injured Employee's: State	M	Text	2	Should be a drop down or valid state should be entered		
	Injured Employee's: Zipcode	M	numeric	5			
Applicant Information Section							
Applicant, if other than injured employee					If Insurance Carrier is checked ; then put the code: DWCCPE0004 into the APPROLE field Else if Employer is checked; then put the code: DWCCPE0001 into the APPROLE field Else if Lien Claimant is checked; then put the code: DWCCPE0005 into the APPROLE field		
	Applicant Role (check box)	O					
Applicant's Address and Zip Code	Insurance Carrier	O	Checkbox	1		Only 1 checkbox can be selected	Must be UAN of Claims Administrator
	Employer	O	Checkbox	1		Only 1 checkbox can be selected	
	Lien Claimant	O	Checkbox	1	Please select only one	Only 1 checkbox can be selected	
	Organization Name	O	Text	56	Name of the organization		
	Applicant's: Street Address 1	CM	Text	40	If Orgname is not null, then AppStreetAddress, AppCity, AppState and AppZip is required		
	Applicants Street Address 2	CM	Text	40			
	Applicant's: City	CM	Text	25	If Orgname is not null, then AppStreetAddress, AppCity, AppState and AppZip is required		
Applicant's: State	CM	Text	2	Should be a valid state abbreviation If Orgname is not null, then AppStreetAddress, AppCity, AppState and AppZip is Required			
Applicant's: Zipcode	CM	Numeric	5	If Orgname is not null, then AppStreetAddress, AppCity, AppState and AppZip is required			
Employer Information Section							
Check Boxes:							
	Insured	M	Check Box	1		Only 1 checkbox can be selected	
	Self-Insured	M	Check Box	1		Only 1 checkbox can be selected	
	Legally Uninsured	M	Check Box	1		Only 1 checkbox can be selected	
	Uninsured	M	Check Box	1	Only One Check Box Can Be Applied	Only 1 checkbox can be selected	
Employer Name	Employer Name	M	Text	56			
Employer's Address and Zip Code	Employer's: Address	M	Text	40			
	Employer's: City	M	Text	25	Cannot contain numbers		
	Employer's: State	M	Text	2	Should be a drop down or valid state should be entered		
	Employer's: Zipcode	M	Numeric	5	Must contain numbers only		
Insurance Carrier Information Section							
	Insurance Carrier Name	O	Text	56	If INSURANCENAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required		
	Insurance Carrier Street Address	CM	Text	40	If INSURANCENAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required		

	Insurance Carrier City	CM	Text	25	If INSURANCE NAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required	
	Insurance Carrier State	CM	Text	2	If INSURANCE NAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required	
	Insurance Carrier Zipcode	CM	numeric	5	If INSURANCE NAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required	
Claims Administrator Information Section						
	Claims Administrator Name	M	Text	56	If CLAIMS ADMIN NAME is not blank, then CLAIMS ADMIN STREET ADDRESS, CLAIMS ADMIN CITY, CLAIMS ADMIN STATE, CLAIMS ADMIN ZIPCODE are required	Must be UJAN
	Claims Administrator Street Address	M	Text	40	If CLAIMS ADMIN NAME is not blank, then CLAIMS ADMIN STREET ADDRESS, CLAIMS ADMIN CITY, CLAIMS ADMIN STATE, CLAIMS ADMIN ZIPCODE are required	
	Claims Administrator City	M	Text	25	If CLAIMS ADMIN NAME is not blank, then CLAIMS ADMIN STREET ADDRESS, CLAIMS ADMIN CITY, CLAIMS ADMIN STATE, CLAIMS ADMIN ZIPCODE are required	
	Claims Administrator State	M	Text	2	If CLAIMS ADMIN NAME is not blank, then CLAIMS ADMIN STREET ADDRESS, CLAIMS ADMIN CITY, CLAIMS ADMIN STATE, CLAIMS ADMIN ZIPCODE are required	
	Claims Administrator Zipcode	M	numeric	5	If CLAIMS ADMIN NAME is not blank, then CLAIMS ADMIN STREET ADDRESS, CLAIMS ADMIN CITY, CLAIMS ADMIN STATE, CLAIMS ADMIN ZIPCODE are required	
IT IS CLAIMED THAT SECTION						
	Employee Date of Birth	M	Date	10	Must be in the format MM/DD/YYYY and we should check to make sure we don't allow DOB to be greater than today	
	Occupation at time of Injury		Text	40		Field wraps to 2 lines
	Check Boxes:					
	Specific Injury	O	Check Box	1	This will be captured from the coversheet and should be disabled in the eform (Field does not exist on Eform)	Only 1 checkbox can be selected
	Cumulative Trauma Injury (CT)	O	Check Box	1	This will be captured from the coversheet and should be disabled in the eform (Field does not exist on Eform)	Only 1 checkbox can be selected
	Date of Injury	O	Date	10	This will be captured from the coversheet and should be disabled in the eform (Field does not exist on Eform)	
	Start Date	O	Date	10	This will be captured from the coversheet and should be disabled in the eform (Field does not exist on Eform)	
	End Date	O	Date	10	This will be captured from the coversheet and should be disabled in the eform (Field does not exist on Eform)	
	Address can only be a CA address					
Injury Address	Injury Street Address	M	Text	40		
	Injury City	M	Text	25		
	Injury State	M	Text	2	Should be a drop down or valid state should be entered	
	Injury Zip	M	Numeric	5	Should be only 5 digits	
Injured Employee: Parts of body injured		Text				
	Body Part 1	O	Text	20	This will be captured from the coversheet and should be disabled in the eform	
	Body Part 2	O	Text	20	This will be captured from the coversheet and should be disabled in the eform	
	Body Part 3	O	Text	20	This will be captured from the coversheet and should be disabled in the eform	
	Body Part 4	O	Text	20	This will be captured from the coversheet and should be disabled in the eform	
	Other Body Parts	O	Text	20	This will be captured from the coversheet and should be disabled in the eform	
2. Explain what employee was doing at the time of injury and how injury was received.						
			Text	325		
3. Actual earning - Give weekly or monthly salary or hourly rate, and number of hours worked	Rate of Pay	O	Float	15		Field will take 9 characters
	Check Boxes:					
	Monthly	O	Check Box	1	User must check one	Only 1 checkbox can be selected
	Weekly	O	Check Box	1	User must check one	Only 1 checkbox can be selected
	Hourly	O	Check Box	1	User must check one	Only 1 checkbox can be selected
	Value of tips, meals, lodging or other	O	Float	15	Round amount to nearest 1/10th of decimal.	Field will take 9 characters
	Check Boxes:					
	Monthly	O	Check Box	1	User must check one	Only 1 checkbox can be selected
	Weekly	O	Check Box	1	User must check one	Only 1 checkbox can be selected
	Hourly	O	Check Box	1	User must check one	Only 1 checkbox can be selected
Number of hours worked per week	O	Numeric	3			
		O				
4. The Injury Caused Disability as Follows:	Last day off work due to injury	O	Date	10	MM/DD/YYYY	
	First Period of Disability: Beginning date 1	O	Date	10	MM/DD/YYYY	
	First Period of Disability: End date 1	O	Date	10	MM/DD/YYYY	

	Second Period of Disability: Beginning date 2	<input type="text"/>	Date	10	MM/DD/YYYY		
	Second Period of Disability: End date 2	<input type="text"/>	Date	10	MM/DD/YYYY		
5. Compensation	Compensation was Paid (Check Box)	<input type="checkbox"/>	Check Box	1	Yes/No	There are 2 checkboxes - "Yes" & "No" Only 1 checkbox can be selected	
	Total Paid	<input type="text"/>	Float	15			
	Weekly rate(s)	<input type="text"/>	Float	15			
	Date of Last Payment	<input type="text"/>	Date	10	MM/DD/YYYY		
6. Has Employee Received Unemployment Insurance	Yes/No (Checkbox)	<input type="checkbox"/>	Check Box	1		There are 2 checkboxes - "Yes" & "No" Only 1 checkbox can be selected	
7. Medical Treatment:	Medical Treatment Received (Checkbox)	<input type="checkbox"/>	Check Box	1	Yes/No	There are 2 checkboxes - "Yes" & "No" Only 1 checkbox can be selected	
	Treatment Furnished By Employer/Carrier	<input type="checkbox"/>	Check Box	1	Yes/No	There are 2 checkboxes - "Yes" & "No" Only 1 checkbox can be selected	
	Date of Last Treatment	<input type="text"/>	Date	10	MM/DD/YYYY		
	Other Treatment Provided By	<input type="text"/>	Text	40			
	Did Medical Pay?	<input type="checkbox"/>	Check Box	1	Yes/No	There are 2 checkboxes "Yes" & "No" Only 1 checkbox can be selected	
	Name of Doctor/Hospital1	<input type="text"/>	Text	80		Filed wraps to 2 lines	
	Name of Doctor/Hospital2	<input type="text"/>	Text	80		Filed wraps to 2 lines	
	Other	<input type="text"/>	Text	20		This field is not on the OCR Form	
8. Other Cases have been filed for Industrial Injuries by this employee as follows:	Case Number 1	<input type="text"/>	Text	12			
	Case Number 2	<input type="text"/>	Text	12			
	Case Number 3	<input type="text"/>	Text	12			
	Case Number 4	<input type="text"/>	Text	12			
9. This application is filed because of a disagreement regarding liability for:	Temporary disability indemnity	<input type="checkbox"/>	Check Box	1		Users can select one or more boxes.	
	Permanent disability indemnity	<input type="checkbox"/>	Check Box	1		Users can select one or more boxes.	
	Reimbursement for medical expense	<input type="checkbox"/>	Check Box	1		Users can select one or more boxes.	
	Medical Treatment	<input type="checkbox"/>	Check Box	1		Users can select one or more boxes.	
	Supplemental Job Displacement/Return to Work	<input type="checkbox"/>	Check Box	1		Users can select one or more boxes.	
	Compensation at proper rate	<input type="checkbox"/>	Check Box	1		Users can select one or more boxes.	
	Rehabilitation	<input type="checkbox"/>	Check Box	1		Users can select one or more boxes.	
	Others (Specify)	<input type="checkbox"/>	Check Box	1	Must be in the format MM/DD/YYYY	Users can select one or more boxes.	
		Other text	<input type="text"/>	Text	20		
	Is Applicant Represented ?	<input type="checkbox"/>	Check Box	1	Yes/No	There are 2 checkboxes - "Yes" & "No" Only 1 checkbox can be selected	
	Law Firm/Attorney	<input type="checkbox"/>	Check Box	1	Only one check box can be selected	Only 1 checkbox can be selected	
	Non Attorney Representative	<input type="checkbox"/>	Check Box	1	Only one check box can be selected	Only 1 checkbox can be selected	
Applicant's Attorney	Law Firm Name	<input type="text"/>	Text	56	IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCITY, LAWFIRMSTATE and LAWFIRMZIP is required		
	Law Firm Number	<input type="text"/>	Number	10			
	Applicant Attorney:First Name	<input type="text"/>	Text	25	IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCITY, LAWFIRMSTATE and LAWFIRMZIP is required		
	Applicant Attorney:Last Name	<input type="text"/>	Text	25	IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCITY, LAWFIRMSTATE and LAWFIRMZIP is required		
	Applicant Attorney:Middle Initial	<input type="text"/>	Text	1			
	Address 1	<input type="text"/>	Text	40	IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCITY, LAWFIRMSTATE and LAWFIRMZIP is required		
	City	<input type="text"/>	Text	25	IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCITY, LAWFIRMSTATE and LAWFIRMZIP is required		
	State	<input type="text"/>	Text	2	IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCITY, LAWFIRMSTATE and LAWFIRMZIP is required		
	Zip	<input type="text"/>	Number	5	IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCITY, LAWFIRMSTATE and LAWFIRMZIP is required		
		Applicant Attorney Signature	<input type="text"/>	Text Box	40		Not a fillable field

							Enter S Signature only if filed by un represented Employer, Claims Administrator's Office or Lien Claimant
Applicant Signature	CM	Text Box	40			Not a fillable field	
Dated At (City)	O	Text	25				
Date	M	Date	10				
		Numeric	10				

BARCODE VALUE = "WCAB1"

STIPULATIONS WITH REQUEST FOR AWA

Legacy Form Field Names	EAMS Form Field Names	Input Criteria (Mandatory M, Optional O, Conditional Mandatory CM)	Data Type	Field Length
CASE SECTION	Case Number		Text	12
	Date of Injury		Date	10
	SSN		Numeric	9
VENUE SECTION	Residence of Employee	M	checkbox	1
	Location where Injury Occurred	M	checkbox	1
	Principal Address of Employees Attorney	M	checkbox	1
	3 Digit Office Code	M	Text	3
APPLICANT SECTION	Applicant First Name	M	Text	25
	Applicant Middle Initial	O	Text	1
	Applicant Last Name	M	Text	25
	Applicant Address	M	Text	40
	Applicant City	M	Text	25
	Applicant State	M	Text	2
	Applicant Zip	M	Numeric	5
EMPLOYER #1 SECTION	EMPLOYER#1 Role Type (Checkbox)			
	Insured	M	checkbox	1
	Self-Insured	M	checkbox	1
	Legally Uninsured	M	checkbox	1
	Uninsured	M	checkbox	1
	Employer # 1 Name	M	Text	56
	Employer # 1 Address	M	text	40
	Employer # 1 City	M	text	25
Employer # 1 State	M	Text	2	
	Employer # 1 Zip	M	Numeric	5
EMPLOYER #1 INSURANCE CARRIER SECTION	Insurance Carrier Name	O	Text	56
	Insurance Carrier Street Address	CM	Text	40

	Insurance Carrier City	CM	Text	25
	Insurance Carrier State	CM	Text	2
	Insurance Carrier Zipcode	CM	numeric	5
EMPLOYER #1 CLAIMS ADMIN SECTION				
	Claims Administrator Name	M	Text	56
	Claims Administrator Street Address	M	Text	40
	Claims Administrator City	M	Text	25
	Claims Administrator State	M	Text	2
	Claims Administrator Zipcode	M	numeric	5
EMPLOYER #2 SECTION				
	EMPLOYER#2 Role Type (Checkbox)			
	Insured	CM	checkbox	1
	Self-Insured	CM	checkbox	1
	Legally Uninsured	CM	checkbox	1
	Uninsured	CM	checkbox	1
	Employer # 2 Name	O	Text	56
	Employer # 2 Address	CM	text	40
	Employer # 2 City	CM	text	25
	Employer # 2 State	CM	Text	2
	Employer # 2 Zip	CM	Numeric	5

<u>EMPLOYER #2 INSURANCE CARRIER SECTION</u>	Insurance Carrier Name	O	Text	56
	Insurance Carrier Street Address	CM	Text	40
	Insurance Carrier City	CM	Text	25
	Insurance Carrier State	CM	Text	2
	Insurance Carrier Zipcode	CM	numeric	5
<u>EMPLOYER #2 CLAIMS ADMIN SECTION</u>	Claims Administrator Name	CM	Text	56
	Claims Administrator Street Address	CM	Text	40
	Claims Administrator City	CM	Text	25
	Claims Administrator State	CM	Text	2
	Claims Administrator Zipcode	CM	numeric	5

EMPLOYER #3 SECTION	EMPLOYER#3 Role Type (Checkbox)			
	Insured	CM	checkbox	1
	Self-Insured	CM	checkbox	1
	Legally Uninsured	CM	checkbox	1
	Uninsured	CM	checkbox	1
	Employer # 3 Name	O	Text	56
	Employer # 3 Address	CM	text	40
	Employer # 3 City	CM	text	25
	Employer # 3 State	CM	Text	2
	Employer # 3 Zip	CM	Numeric	5
EMPLOYER #3 INSURANCE CARRIER SECTION	Insurance Carrier Name	O	Text	56
	Insurance Carrier Street Address	CM	Text	40
	Insurance Carrier City	CM	Text	25
	Insurance Carrier State	CM	Text	2
	Insurance Carrier Zipcode	CM	numeric	5

EMPLOYER #3 CLAIMS ADMIN SECTION	Claims Administrator Name	CM	Text	56
	Claims Administrator Street Address	CM	Text	40
	Claims Administrator City	CM	Text	25
	Claims Administrator State	CM	Text	2
	Claims Administrator Zipcode	CM	numeric	5
EMPLOYER #4 SECTION	EMPLOYER#4 Role Type (Checkbox)			
	Insured	CM	checkbox	1
	Self-Insured	CM	checkbox	1
	Legally Uninsured	CM	checkbox	1
	Uninsured	CM	checkbox	1
	Employer # 4 Name	O	Text	56
	Employer # 4 Address	CM	text	40
	Employer # 4 City	CM	text	25
	Employer # 4 State	CM	Text	2
	Employer # 4 Zip	CM	Numeric	5

<u>EMPLOYER #4 INSURANCE CARRIER SECTION</u>	Insurance Carrier Name	O	Text	56
	Insurance Carrier Street Address	CM	Text	40
	Insurance Carrier City	CM	Text	25
	Insurance Carrier State	CM	Text	2
	Insurance Carrier Zipcode	CM	numeric	5
<u>EMPLOYER #4 CLAIMS ADMIN SECTION</u>	Claims Administrator Name	CM	Text	56
	Claims Administrator Street Address	CM	Text	40
	Claims Administrator City	CM	Text	25
	Claims Administrator State	CM	Text	2
	Claims Administrator Zipcode	CM	numeric	5
<u>GENERAL SECTION</u>				

SECTION 1	Employee First Name	O	Text	25
	Employee Last Name	O	Text	25
	Date of Birth	M	date	10
	Employed at Location	O	Text	40
	State	O	Text	2
	Occupation	O	Text	40
	Group	O	Text	10
	More than 4 companion cases (Checkbox)	O	Checkbox	1
	Case #1	O	Text	12
	Specific Injurv (Checkbox)	O	Checkbox	1
	Cumulative Trauma (Checkbox)	O	Checkbox	1
	Start Date	O	Date	10
	End Date	O	Date	10
	Body Part 1	O	Text	20
	Body Part 2	O	Text	20
	Body Part 3	O	Text	20
	Body Part 4	O	Text	20
	Other Body Parts	O	Text	20
	Case #2	O	Text	12
	Specific Injurv (Checkbox)	O	Checkbox	1
	Cumulative Trauma (Checkbox)	O	Checkbox	1
	Start Date	O	Date	10
	End Date	O	Date	10
	Body Part 1	O	Text	20
	Body Part 2	O	Text	20
	Body Part 3	O	Text	20
	Body Part 4	O	Text	20
	Other Body Parts	O	Text	20
	Case #3	O	Text	12
	Specific Injurv (Checkbox)	O	Checkbox	1
	Cumulative Trauma (Checkbox)	O	Checkbox	1
	Start Date	O	Date	10
	End Date	O	Date	10
	Body Part 1	O	Text	20
	Body Part 2	O	Text	20
	Body Part 3	O	Text	20
	Body Part 4	O	Text	20
	Other Body Parts	O	Text	20
	Case #4	O	Text	12
	Specific Injurv (Checkbox)	O	Checkbox	1
	Cumulative Trauma (Checkbox)	O	Checkbox	1
	Start Date	O	Date	10
	End Date	O	Date	10
	Body Part 1	O	Text	20
	Body Part 2	O	Text	20
	Body Part 3	O	Text	20
	Body Part 4	O	Text	20
	Other Body Parts	O	Text	20
	Employer(s)	O	Text	40
	Insurance Carrier(s)	O	Text	40

	List of Body Parts	O	Text	455
SECTION 2 - Temporary Disability Period	Disability Period Begin Date	O	Date	10
	Disability Period End Date	O	Date	10
	Indemnity paid per week	O	Float	15
SECTION 2A - Additional Indemnity Paid	Additional Temporary Disability Start Date	O	Date	10
	Additional Temporary Disability End Date	O	Date	10
	Rate	O	Float	15
	Amount of	O	Float	15
SECTION 3	Permanent Disability Percentage	M	numeric	5
	Indemnity paid per week	M	Float	15
	Payment per week beginning date	O	date	10
	sum of	O	Float	15
	life pension	O	Checkbox	1
	life pension amount	O	Float	15
	Rate Increase Checkbox	O	checkbox	1
	Rate increase to		Float	15
	Rate increase Date		date	10
	Decrease Rate Checkbox	O	checkbox	1
	Decrease rate to		Float	15
	Decrease rate Date		date	10
	Not Applicable Checkbox	O	checkbox	1
	Informal Rating Checkbox (Has/Has Not)	O	Checkbox	1
	Case No	O	Text	12
SECTION 4	Medical Treatment (Checkbox) (Is/Is Not)	M	checkbox	1
SECTION 5	Medical Expenses to be paid by Defendants as follows	O	Text	189
SECTION 6	Applicant's Attorney Requests Fee of	O	Float	15
	Fees to be commuted as follows (Checkbox)	O	checkbox	1
	Fees to be commuted Text	O	Text	256
SECTION 7	Liens against compensation	O	Text	440
SECTION 8	N/A			
SECTION 9	Other Stipulations	O	Text	1024
	Dated		Date	10
	Applicant Signature		Text	40
APPLICANT'S ATTORNEY SECTION	Role Type (Checkbox)			

	Law Firm/Attorney	CM	Checkbox	1
	Non Attorney Representative	CM	Checkbox	1
	Firstname	O	Text	25
	Last name	O	Text	25
	Law Firm Number	O	Text	10
	Law Firm Name	O	Text	56
	Law Firm Address	CM	Text	40
	Law Firm City	CM	Text	25
	Law Firm State	CM	Text	2
	Law Firm Zip	CM	Numeric	5
	Dated	O	Date	10
	Applicant Attorney Signature	O	Text	40
DEFENDANT'S ATTORNEY OR AUTHORIZED REP SECTION 1	Role Type (Checkbox)	O		
	Law Firm/Attorney	CM	Checkbox	1

	Non Attorney Representative	CM	Checkbox	1
	Firstname	O	Text	25
	Last name	O	Text	25
	Law Firm Number	O	Text	10
	Law Firm Name	O	Text	56
	Law Firm Address	CM	Text	40
	Law Firm City	CM	Text	25
	Law Firm State	CM	Text	2
	Law Firm Zip	CM	Numeric	5
	Dated	O	Date	10
	Defense Attorney Signature		Text	40
DEFENDANT'S ATTORNEY OR AUTHORIZED REP SECTION 2	Role Type (Checkbox)			
	Law Firm/Attorney	CM	Checkbox	1
	Non Attorney Representative	CM	Checkbox	1
	Firstname		Text	25
	Last name	O	Text	25
	Law Firm Number	O	Text	10
	Law Firm Name	O	Text	56
	Law Firm Address	CM	Text	40

	Law Firm City	CM	Text	25
	Law Firm State	CM	Text	2
	Law Firm Zip	CM	Numeric	5
	Dated	O	Date	10
	Defense Attorney Signature		Text	40
DEFENDANT'S ATTORNEY OR AUTHORIZED REP SECTION 3	Role Type (Checkbox)			
	Law Firm/Attorney	CM	Checkbox	1
	Non Attorney Representative	CM	Checkbox	1
	Firstname		Text	25
	Last name	O	Text	25
	Law Firm Number	O	Text	10
	Law Firm Name	O	Text	56
	Law Firm Address	CM	Text	40
	Law Firm City	CM	Text	25
	Law Firm State	CM	Text	2
	Law Firm Zip	CM	Numeric	5
	Dated	O	Date	10
	Defense Attorney Signature		Text	40
INTERPRETER LICENSE SECTION	Interpreter Name	O	Text	40
	Interpreter License Number	O	Text	15

BARCODE VALUE = "WCAB3"

<p>If INSURANCENAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required</p>		
<p>If INSURANCENAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required</p>		
<p>If INSURANCENAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required</p>		
<p>If EMPLOYER#2 NAME is not blank, then the user must select one of the checkboxes/radio buttons</p>	<p>Only 1 checkbox can be selected Only 1 checkbox can be selected Only 1 checkbox can be selected Only 1 checkbox can be selected</p>	
<p>If EMPLOYER#2 NAME is not blank, then EMPLOYER#2 ADDRESS, CITY, STATE, ZIP are required</p>		
<p>If EMPLOYER#2 NAME is not blank, then EMPLOYER#2 ADDRESS, CITY, STATE, ZIP are required</p>		
<p>If EMPLOYER#2 NAME is not blank, then EMPLOYER#2 ADDRESS, CITY, STATE, ZIP are required</p>		
<p>If EMPLOYER#2 NAME is not blank, then EMPLOYER#2 ADDRESS, CITY, STATE, ZIP are required</p>		

If EMPLOYER#3 NAME is not blank, then CLAIMS ADMINISTRATOR NAME, STREET, CITY, STATE, ZIP are required		
If EMPLOYER#3 NAME is not blank, then CLAIMS ADMINISTRATOR NAME, STREET, CITY, STATE, ZIP are required		
If EMPLOYER#3 NAME is not blank, then CLAIMS ADMINISTRATOR NAME, STREET, CITY, STATE, ZIP are required		
If EMPLOYER#3 NAME is not blank, then CLAIMS ADMINISTRATOR NAME, STREET, CITY, STATE, ZIP are required		
If EMPLOYER#3 NAME is not blank, then CLAIMS ADMINISTRATOR NAME, STREET, CITY, STATE, ZIP are required		
If EMPLOYER#4 NAME is not blank, then the user must select one of the checkboxes/radio buttons	Only 1 checkbox can be selected	
	Only 1 checkbox can be selected	
	Only 1 checkbox can be selected	
	Only 1 checkbox can be selected	
If EMPLOYER#4 NAME is not blank, then EMPLOYER#2 ADDRESS, CITY, STATE, ZIP are required		
If EMPLOYER#4 NAME is not blank, then EMPLOYER#2 ADDRESS, CITY, STATE, ZIP are required		
If EMPLOYER#4 NAME is not blank, then EMPLOYER#2 ADDRESS, CITY, STATE, ZIP are required		
If EMPLOYER#4 NAME is not blank, then EMPLOYER#2 ADDRESS, CITY, STATE, ZIP are required		

If INSURANCENAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required		
If INSURANCENAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required		
If INSURANCENAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required		
If INSURANCENAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required		
If INSURANCENAME is not blank, then INSURANCE CARRIER STREET ADDRESS, INSURANCE CARRIER CITY, INSURANCE CARRIER STATE, INSURANCE CARRIER ZIPCODE are required		
If EMPLOYER#4 NAME is not blank, then CLAIMS ADMINISTRATOR NAME, STREET, CITY, STATE, ZIP are required		
If EMPLOYER#4 NAME is not blank, then CLAIMS ADMINISTRATOR NAME, STREET, CITY, STATE, ZIP are required		
If EMPLOYER#4 NAME is not blank, then CLAIMS ADMINISTRATOR NAME, STREET, CITY, STATE, ZIP are required		
If EMPLOYER#4 NAME is not blank, then CLAIMS ADMINISTRATOR NAME, STREET, CITY, STATE, ZIP are required		
If EMPLOYER#4 NAME is not blank, then CLAIMS ADMINISTRATOR NAME, STREET, CITY, STATE, ZIP are required		

This field will be picked up from the coversheet		
This field will be picked up from the coversheet		
This field will be picked up from the coversheet	Only 1 checkbox can be selected	
This field will be picked up from the coversheet	Only 1 checkbox can be selected	
This field will be picked up from the coversheet		
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This field will be picked up from the coversheet		
This field will be picked up from the coversheet		
This field will be picked up from the coversheet	Only 1 checkbox can be selected	
This field will be picked up from the coversheet	Only 1 checkbox can be selected	
This field will be picked up from the coversheet		
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This field will be picked up from the coversheet		
This field will be picked up from the coversheet		
This field will be picked up from the coversheet		
This field will be picked up from the coversheet	Only 1 checkbox can be selected	
This field will be picked up from the coversheet	Only 1 checkbox can be selected	
This field will be picked up from the coversheet		
This field will be picked up from the coversheet		
This field will be picked up from the coversheet		
This field will be picked up from the coversheet		
This field will be picked up from the coversheet		
This field will be picked up from the coversheet		
	This field is not on the OCR form	
	This field is not on the OCR form	

IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then one checkbox/radio button must be selected	Only 1 checkbox can be selected	
IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then one checkbox/radio button must be selected	Only 1 checkbox can be selected	
		Must be UAN
IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRM CITY, LAWFIRMSTATE and LAWFIRMZIP is required		
IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRM CITY, LAWFIRMSTATE and LAWFIRMZIP is required		
IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRM CITY, LAWFIRMSTATE and LAWFIRMZIP is required		
IF APPATTORNEY FIRSTNAME or APPATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRM CITY, LAWFIRMSTATE and LAWFIRMZIP is required		
	Not a fillable field	No S Signature because wet signed settlement is attached
IF DEFATTORNEY FIRSTNAME or DEFATTORNEYLASTNAME or LAWFIRMNAME is entered, then one checkbox/radio button must be selected	Only 1 checkbox can be selected	

IF DEFATTORNEY FIRSTNAME or DEFATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCIY, LAWFIRMSTATE and LAWFIRMZIP is required		
IF DEFATTORNEY FIRSTNAME or DEFATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCIY, LAWFIRMSTATE and LAWFIRMZIP is required		
IF DEFATTORNEY FIRSTNAME or DEFATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCIY, LAWFIRMSTATE and LAWFIRMZIP is required		
	Not a fillable field	No S Signature because wet signed settlement is attached
IF DEFATTORNEY FIRSTNAME or DEFATTORNEYLASTNAME or LAWFIRMNAME is entered, then one checkbox/radio button must be selected	Only 1 checkbox can be selected	
IF DEFATTORNEY FIRSTNAME or DEFATTORNEYLASTNAME or LAWFIRMNAME is entered, then one checkbox/radio button must be selected	Only 1 checkbox can be selected	
		Must be UAN
IF DEFATTORNEY FIRSTNAME or DEFATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCIY, LAWFIRMSTATE and LAWFIRMZIP is required		
IF DEFATTORNEY FIRSTNAME or DEFATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCIY, LAWFIRMSTATE and LAWFIRMZIP is required		
IF DEFATTORNEY FIRSTNAME or DEFATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCIY, LAWFIRMSTATE and LAWFIRMZIP is required		
IF DEFATTORNEY FIRSTNAME or DEFATTORNEYLASTNAME or LAWFIRMNAME is entered, then LAWFIRMSTREETADDRESS, LAWFIRMCIY, LAWFIRMSTATE and LAWFIRMZIP is required		
	Not a fillable field	No S Signature because wet signed settlement is attached
	Not a fillable field	

Legacy Form Field Names	EAMS Form Field Names	Input Criteria (Mandatory M, Optional O, Conditional Mandatory CM)	Data Type	Field Length	Validation Rules
	Case Number	M	Text	12	The case number is required on the coversheet. We will not allow case number to be entered on this form. It should be greved out on the eform
Applicant Information Section	Applicant First Name	M	Text	25	This is required and should be marked by an asterisk
	Applicant Last Name	M	Text	25	This is required and should be marked by an asterisk
	Applicant MI	O	Text	1	Added 10/09/07
Employer Information Section					
	Employer Name	M	Text	56	If EmployerName is not null, then Employer Street Address, Employer City, Employer State and Employer Zip is required
	Employer Street Address	M	Text	40	If EmployerName is not null, then Employer Street Address, Employer City, Employer State and Employer Zip is required
	Employer City	M	Text	25	If EmployerName is not null, then Employer Street Address, Employer City, Employer State and Employer Zip is required
	Employer State	M	Text	2	If EmployerName is not null, then Employer Street Address, Employer City, Employer State and Employer Zip is required
	Emplyer Zip	M	Numeric	5	If EmployerName is not null, then Employer Street Address, Employer City, Employer State and Employer Zip is required
Declarant Requests Section	Entitlement to Medical Treatment (As is from the form)	O	Check Box	1	
	Entitlement to Temporary Disability (As is from the form)	O	Check Box	1	
	Appeal from Determination of the Rehab Unit (As is from the form)	O	Check Box	1	
	Entitlement to Compensation (As is from the form)	O	Check Box	1	
Declarant States Section					
	Declarant states under penalty	O	Text	455	
	Declarant Signature	M	Text	40	
	Law Firm Name	M	Text	56	
	Law Firm Address	M	Text	40	
	Phone Number	O	numeric	10	
	Date	M	Date	10	MM/DD/YYYY

BARCODE VALUE = "WCABFORM4"

Legacy Form Field Names	EAMS Form Field Names	Input Criteria (Mandatory M, Optional O, Conditional C, Mandatory CM)	Data Type	Field Length	Validation Rules
LIEN INFORMATION SECTION					
	Case Number	M	Text	13	This will be captured from the cover sheet and should be disabled in the system
	Date of Original Lien	CM	Date	10	MMDDYYYY - The original lien date is required if the amended lien check box is selected otherwise not required
	LIEN TYPE (checkboxes Only One Selection)				
	Original Lien	M	Checkbox	1	One of the Lien Checkboxes must be selected. This is a required checkbox
	Amended Lien	M	Checkbox	1	This will be captured from the cover sheet and should be disabled in the system
	Specific Injury Date Check box		Checkbox	1	This will be captured from the cover sheet and should be disabled in the system
	Specific Date of Injury		Date	10	This will be captured from the cover sheet and should be disabled in the system
	Cumulative Trauma Check Box		Checkbox	1	This will be captured from the cover sheet and should be disabled in the system
	Start Date of Injury		Date	10	This will be captured from the cover sheet and should be disabled in the system
	End Date of Injury		Date	10	This will be captured from the cover sheet and should be disabled in the system
	SSN		Number	9	This will be captured from the cover sheet and should be disabled in the system
	Date of Birth		Date	10	MMDDYYYY
INURED WORKER SECTION					
	Employee First Name		Text	28	
	Employee Last Name		Text	28	
	Employee MI		Text	1	
	Employee Street Address		Text	48	
	Employee City		Text	28	
	Employee State		Text	2	
	Employee Zip		Text	5	
INURED WORKER ATTORNEY SECTION					
	Attorney Firm Name		Text	48	
	Attorney Firm Street Address		Text	48	
	Attorney Firm City		Text	28	
	Attorney Firm State		Text	2	
	Attorney Firm Zip		Text	5	
LIEN CLAIMANT SECTION					
	Lien Claimant Place/Residence	CM	Text	48	Validations have changed as of 08/12/08. New validation is either the Lien Claimant Organization is Required or the Lien Claimant First Name and Last Name. Do not enter both. Only enter 1 or the other
	Lien Claimant First Name	CM	Text	28	Validations have changed as of 08/12/08. New validation is either the Lien Claimant Organization is Required or the Lien Claimant First Name and Last Name. Do not enter both. Only enter 1 or the other
	Lien Claimant Last Name	CM	Text	28	Validations have changed as of 08/12/08. New validation is either the Lien Claimant Organization is Required or the Lien Claimant First Name and Last Name. Do not enter both. Only enter 1 or the other
	Lien Claimant Street Address	M	Text	48	IF LIENCLAMANTORGNAME, LIENCLAMANTFIRSTNAME or LIENCLAMANTLASTNAME is not null, then LIENCLAMANTSTREETADDR, LIENCLAMANTCITY, LIENCLAMANTSTATE, LIENCLAMANTZIP are Required
	Lien Claimant City	M	Text	28	IF LIENCLAMANTORGNAME, LIENCLAMANTFIRSTNAME or LIENCLAMANTLASTNAME is not null, then LIENCLAMANTSTREETADDR, LIENCLAMANTCITY, LIENCLAMANTSTATE, LIENCLAMANTZIP are Required
	Lien Claimant State	M	Text	2	IF LIENCLAMANTORGNAME, LIENCLAMANTFIRSTNAME or LIENCLAMANTLASTNAME is not null, then LIENCLAMANTSTREETADDR, LIENCLAMANTCITY, LIENCLAMANTSTATE, LIENCLAMANTZIP are Required
	Lien Claimant Zip	M	Text	5	IF LIENCLAMANTORGNAME, LIENCLAMANTFIRSTNAME or LIENCLAMANTLASTNAME is not null, then LIENCLAMANTSTREETADDR, LIENCLAMANTCITY, LIENCLAMANTSTATE, LIENCLAMANTZIP are Required
	Lien Claimant Phone	O	Text	10	
LIEN CLAIMANT ATTORNEY/REP SECTION					
	Lien Firm Attorney (Check box)	CM	Checkbox	1	IF LIENCLAMANTLAWFIRM, LIENCLAMANTATTORNAME or LIENCLAMANTATTLASTNAME is not null, then this checkbox is Required
	Has Attorney (Check Box)	CM	Checkbox	1	IF LIENCLAMANTLAWFIRM, LIENCLAMANTATTORNAME or LIENCLAMANTATTLASTNAME is not null, then this checkbox is Required
	Lien Claimant Not Represented (Check Box)	O	Checkbox	1	
	Lien Claimant Law Firm	CM	Text	48	IF LIENCLAMANTLAWFIRM, LIENCLAMANTATTORNAME or LIENCLAMANTATTLASTNAME is not null, then LIENCLAMANTATTORNAME, LIENCLAMANTATTORADDRESS, LIENCLAMANTATTORCITY, LIENCLAMANTATTORSTATE, LIENCLAMANTATTORZIP are Required
	Lien Claimant Attorney First Name	CM	Text	28	IF LIENCLAMANTLAWFIRM, LIENCLAMANTATTORNAME or LIENCLAMANTATTLASTNAME is not null, then LIENCLAMANTATTORNAME, LIENCLAMANTATTORADDRESS, LIENCLAMANTATTORCITY, LIENCLAMANTATTORSTATE, LIENCLAMANTATTORZIP are Required
	Lien Claimant Attorney Last Name	CM	Text	28	IF LIENCLAMANTLAWFIRM, LIENCLAMANTATTORNAME or LIENCLAMANTATTLASTNAME is not null, then LIENCLAMANTATTORNAME, LIENCLAMANTATTORADDRESS, LIENCLAMANTATTORCITY, LIENCLAMANTATTORSTATE, LIENCLAMANTATTORZIP are Required
	Lien Claimant Attorney Address	CM	Text	48	IF LIENCLAMANTLAWFIRM, LIENCLAMANTATTORNAME or LIENCLAMANTATTLASTNAME is not null, then LIENCLAMANTATTORNAME, LIENCLAMANTATTORADDRESS, LIENCLAMANTATTORCITY, LIENCLAMANTATTORSTATE, LIENCLAMANTATTORZIP are Required
	Lien Claimant Attorney City	CM	Text	28	IF LIENCLAMANTLAWFIRM, LIENCLAMANTATTORNAME or LIENCLAMANTATTLASTNAME is not null, then LIENCLAMANTATTORNAME, LIENCLAMANTATTORADDRESS, LIENCLAMANTATTORCITY, LIENCLAMANTATTORSTATE, LIENCLAMANTATTORZIP are Required
	Lien Claimant Attorney State	CM	Text	2	IF LIENCLAMANTLAWFIRM, LIENCLAMANTATTORNAME or LIENCLAMANTATTLASTNAME is not null, then LIENCLAMANTATTORNAME, LIENCLAMANTATTORADDRESS, LIENCLAMANTATTORCITY, LIENCLAMANTATTORSTATE, LIENCLAMANTATTORZIP are Required
	Lien Claimant Attorney Zip	CM	Text	5	IF LIENCLAMANTLAWFIRM, LIENCLAMANTATTORNAME or LIENCLAMANTATTLASTNAME is not null, then LIENCLAMANTATTORNAME, LIENCLAMANTATTORADDRESS, LIENCLAMANTATTORCITY, LIENCLAMANTATTORSTATE, LIENCLAMANTATTORZIP are Required
	Lien Claimant Attorney Phone	O	Text	10	
EMPLOYER SECTION					
	Employer Name	O	Text	28	
	Employer Address	O	Text	48	
	Employer City	O	Text	28	
	Employer State	O	Text	2	
	Employer Zip	O	Text	5	
INSURANCE CARRIER/CLAIMS ADMIN SECTION					
	Insurance Carrier/Name Admin	M	Text	28	
	Insurance Address	M	Text	48	
	Insurance City	M	Text	28	
	Insurance State	M	Text	2	
	Insurance Zip	M	Text	5	
EMPLOYER OR CLAIMS ADMIN ATTORNEY SECTION					
	Employer Attorney Name	O	Text	28	
	Employer Attorney Address	O	Text	48	
	Employer Attorney City	O	Text	28	
	Employer Attorney State	O	Text	2	
	Employer Attorney Zip	O	Text	5	
OTHER SECTION/PAGES					
	Lien Sign	M	Text	10	
	Request for Lien (Checkboxes)				The user can select one or more of the checkboxes. At least one checkbox must be chosen
	A reasonable attorney's fees for legal services ...	O	Checkbox	1	
	Reasonable expenses incurred by service	O	Checkbox	1	
	Reasonable expenses injured medical expenses	O	Checkbox	1	
	The reasonable value of living expenses for dependents	O	Checkbox	1	
	Reasonable Burial Expenses	O	Checkbox	1	
	The reasonable value of living expenses for spouse and minor children	O	Checkbox	1	
	Reasonable Fee for Interpreter Services	O	Checkbox	1	
	Interpreter Services Performed On ... (Page)		Text	10	
	Mail		Text	10	
	Security		Text	10	
	The amount of indemnification	O	Text	10	
	The amount of Compensation	O	Text	10	
	Other Lines	O	Text	10	
	Contestive	O	Text	10	cont
	Copy of Lien Claim	O	Text	10	
	Signature of Attorney for Lien Claimant	CM	Text	48	If represented, \$ Signature of representative required here
	Signature of Lien Claimant	CM	Text	48	If not represented and filed by lien claimant, \$ Signature required here
	Signature Date	M	Date	10	MMDDYYYY
	Signature Date (M - 10/1/2008)		Date	10	MMDDYYYY

Declaration of Readiness to Proceed							
Legacy Form Field Names	EAMS Form Field Names	Input Criteria (Mandatory M, Optional O, Conditional C)	Data Type	Field Length	Validation Rules	OCR Specifications	Comments
					This information will actually be captured from the mandatory cover sheet		
APPLICANT SECTION							
	Case Number	M	Text	17			
	First Name	M	Text	25			
	Last Name	M	Text	25			
	Middle Initial	O	Text	1			
EMPLOYER INFORMATION SECTION							
	Employer Name	M	Text	56			
	Employer Street Address	M	Text	40	If EmployerName is not null, then Employer Street Address, Employer City, Employer State and Employer Zip is required		
	Employer City	M	Text	25	If EmployerName is not null, then Employer Street Address, Employer City, Employer State and Employer Zip is required		
	Employer State	M	Text	2	If EmployerName is not null, then Employer Street Address, Employer City, Employer State and Employer Zip is required		
	Employer Zip	M	Numeric	5	If EmployerName is not null, then Employer Street Address, Employer City, Employer State and Employer Zip is required		
APPLICANT TYPE SECTION							
	Declarant Role (Checkbox)				Only one role can be selected IF EMPLOYEEIND then put 'DWCCPP0001' in the APPROLE field		
	Employee	M	Check Box	1		Only 1 checkbox can be selected	
	Applicant	M	Check Box	1	IF APPLICANTIND then put 'DWCCPP0013' in the APPROLE field	Only 1 checkbox can be selected	
	Defendant	M	Check Box	1	IF DEFENDANTIND then put 'DWCCPE0001' in the APPROLE field	Only 1 checkbox can be selected	
	Lien Claimant	M	Check Box	1	IF LIENCLAIMANTIND the put 'DWCCPE0005' in the APPROLE field	Only 1 checkbox can be selected	
DECLARANT REQUEST SECTION							
	Declarant Request Type (Checkbox)				Only one can be selected. Even though this is not picked up for Curam, we should only allow one check box to be selected on the Form		
	Mandatory Settlement Conference	M	Check Box	1	Added 01/14/08	Only 1 checkbox can be selected	
	Status Conference	M	Check Box	1	Added 01/14/08	Only 1 checkbox can be selected	
	Retain MSC	M	Check Box	1	Added 01/14/08	Only 1 checkbox can be selected	
	Priority Conference	M	Check Box	1	Added 01/14/08	Only 1 checkbox can be selected	
	Select a Hearing Date from the drop down list		NR/DY/WW	10	THIS IS NOT AVAILABLE TO SETP FILE FRS		Only 1 date can be selected Not captured in Holdinglink Continued in Curam
	Alternate Hearing Date		NR/DY/WW		THIS IS NOT AVAILABLE TO SETP FILE FRS		Only 1 date can be selected Not captured in Holdinglink Continued in Curam
PRINCIPAL ISSUES SECTION							
	Principal Issues (Checkbox)				Users can select one or more boxes. Even though not captured for Curam, we must allow them to select more than one box		
	Communication Date	O	Check Box	1		Users can select one or more boxes. Atleast one checkbox must be chosen	Not captured in Holdinglink
	Permanent Disability	O	Check Box	1		Users can select one or more boxes. Atleast one checkbox must be chosen	Not captured in Holdinglink
	Employment	O	Check Box	1		Users can select one or more boxes. Atleast one checkbox must be chosen	Not captured in Holdinglink
	Rehabilitation/SIPR	O	Check Box	1		Users can select one or more boxes. Atleast one checkbox must be chosen	Not captured in Holdinglink
	Future Medical Treatment	O	Check Box	1		Users can select one or more boxes. Atleast one checkbox must be chosen	Not captured in Holdinglink
	Other	O	Check Box	1		Users can select one or more boxes. Atleast one checkbox must be chosen	Not captured in Holdinglink
	Other Comment Field	O	Text	20			Not captured in Holdinglink
	Temporary Disability	O	Check Box	1		Users can select one or more boxes. Atleast one checkbox must be chosen	Not captured in Holdinglink
	ALICE/ONE	O	Check Box	1		Users can select one or more boxes. Atleast one checkbox must be chosen	Not captured in Holdinglink
	Self-Admin Treatment	O	Check Box	1		Users can select one or more boxes. Atleast one checkbox must be chosen	Not captured in Holdinglink
	Discovery	O	Check Box	1		Users can select one or more boxes. Atleast one checkbox must be chosen	Not captured in Holdinglink
	Doctor(s)	O	Text	40			Not captured in Holdinglink
	Doctor(s) Dated Material	O	Date	10	MM/DD/YYYY		Not captured in Holdinglink
	Declarant States Under Penalty	O	Text	645			Not captured in Holdinglink. Nothing to stop me from entering much more than 645
	Declarant's Signature	M	Text	40		S Signature required	Not captured in Holdinglink
	Name and Law Firm	M	Text	56		Must use IAN	Not captured in Holdinglink
	Law Firm Address	M	Text	66			Not captured in Holdinglink
	Law Firm Phone Number	M	Numeric	10			Not captured in Holdinglink
	Date	M	Date	10	MM/DD/YYYY		Not captured in Holdinglink

BARCODE VALUE = "WCAB9"

