How to file a lien

Filing a notice and request for allowance of lien is how you make a claim for payment of money you're owed in a workers' compensation case.

Attached is a lien form. Complete the form. Be sure to sign and date it. This form can also be completed at: http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCForm6.pdf.

A Workers' Compensation Appeals Board (WCAB) case number must be entered in the top right hand corner of the lien. If there is no WCAB case number, contact the local Information & Assistance (I&A) office.

Send the original to your local WCAB office and copies to all the parties.

Submit the following documents with your form filing in the order shown:

- ✓ Document Cover Sheet
- ✓ Document Separator Sheet (for Notice and Request for Allowance of Lien)
- ✓ Notice and request for allowance of lien
- ✓ Document Separate Sheet (for 10770.5 Verification)
- ✓ Lien Verification 10770.5
- ✓ Document Separate Sheet (for Proof of Service By Mail)
- ✓ Proof of Service by Mail

There are time limits to file for medical providers and medical-legal lien claimants. Also these parties are limited to jet filing or e-filing. Such liens must be filed:

1. For services provided prior to July 1, 2013, within three years from the last date services were provided.

2. For services provided after July 1, 2013, within 18 months from the last date services were provided.

Keep copies of your filings for your records.

All documents filed with the WCAB must include a document cover sheet and document separator sheet. Please see I&A guides 17 and 18 to learn how to complete these forms. In addition all forms must be typed or handwritten in block letters to insure legibility. Additional form instructions can be found on the EAMS OCR handbook at: http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf.

If you need help, call an Information and Assistance (I&A) office, or attend a workshop for injured workers. The local I&A phone numbers are attached to this guide. You can get information on a local workshop from the I&A office or on the Web at www.dir.ca.gov/dwc.

If you do not have the name and address of your insurance company to complete a form, please link to this site http://www.dir.ca.gov/DWC/EAMS/EAMS-LC/EAMSClaimsAdmins.asp.

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations different than those present here.

When sending documents to a district office, please make sure they are not folded or stapled. Send them in a large manila envelope. Please see the EAMS OCR handbook for further instructions.

WORKERS' COMPENSATION APPEALS BOARD
DISTRICT OFFICES

ANAHEIM, 92806-2131
1065 N PacifiCenter 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**

Rev. 5/16

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 ☐

_____ SSN: _____

Date:(MM/DD/YYYY)

☐ Specific Injury

_____ ☐ Cumulative Injury _____ _____

Case Number 1 (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

_____ ☐ Cumulative Injury _____ _____

Case Number 2 (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

Legend	
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.

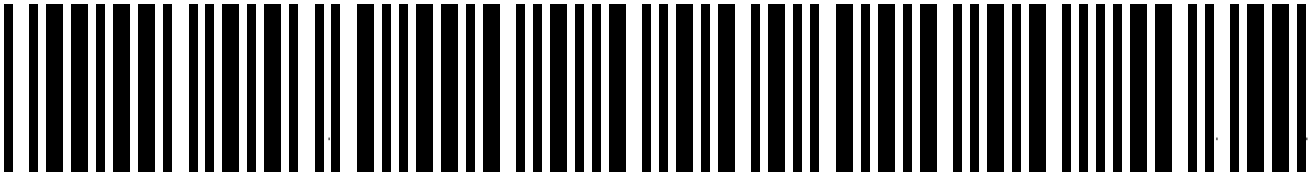
100	Head - not specified
110	Brain
120	Ear - not specified
121	Ear - external
124	Ear - internal including hearing
130	Eye - including optic nerves and vision
140	Face - not specified
141	Jaw - including chin and mandible
144	Mouth - including lips, tongue, throat and taste
145	Teeth
146	Nose - including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

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

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

SAMPLE

DOCUMENT COVER SHEET



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

More than 15 Companion Cases ☐

TODAY'S DATE
Date:(MM/DD/YYYY)

SSN: YOUR SOCIAL SECURITY NUMBER

☐ Specific Injury

EAMS CASE NUMBER
Case Number 1

☐ Cumulative Injury

DATE OF INJURY
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

IF NEW CASE LEAVE BLANK

Body Part 1: _____ ← USE CODE FROM BODY PART CODE LIST, SEE PAGE 8

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: WHEN MORE THAN 5 BODY PARTS USE BODY PART NUMBER 700 IN THIS FIELD

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: _____

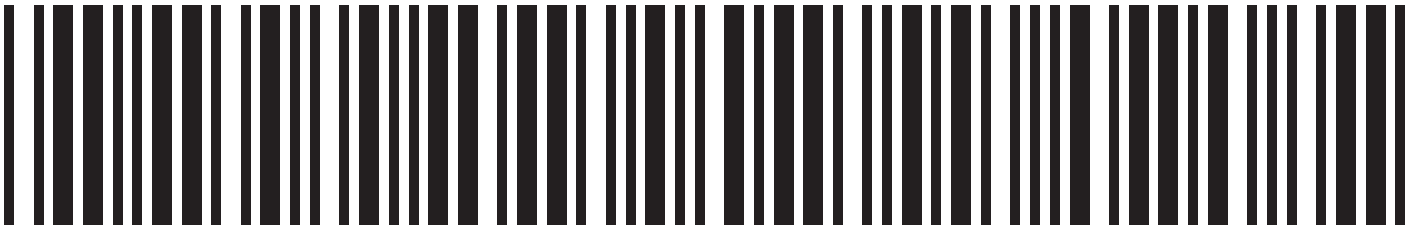
Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

DOCUMENT SEPARATOR SHEET



Product Delivery Unit _____

Document Type _____

Document Title _____

Document Date _____
MM/DD/YYYY

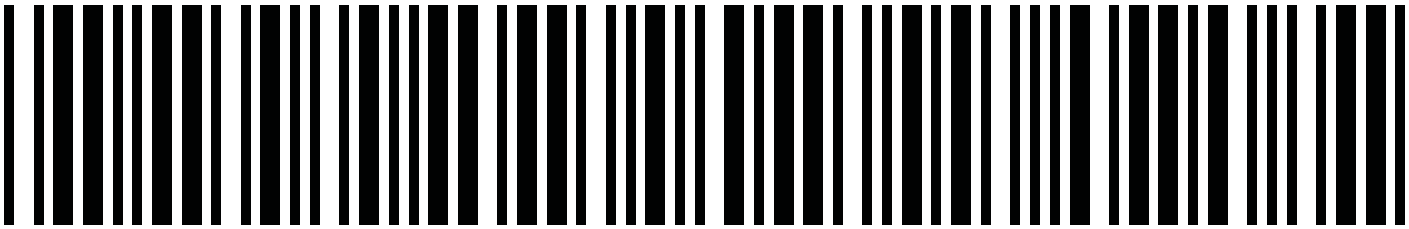
Author _____

Office Use Only

Received Date _____
MM/DD/YYYY

DOCUMENT SEPARATOR SHEET

SAMPLE



Product Delivery Unit: ADJ

Document Type: LIENS AND BILLS

Document Title: NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: IF YOU ARE THE INJURED WORKER, USE YOUR NAME. IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OR LAW FIRM -- USE YOUR UNIFORM ASSIGNED NAME.

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: _____ ☐ Original Lien ☐ Amended Lien
MM/DD/YYYY

_____
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
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):

- ☐ 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

SAMPLE

Date Of Original Lien: _____ ☐ Original Lien ☐ Amended Lien
MM/DD/YYYY

EAMS CASE NUMBER
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)

INJURED WORKER'S SSN
SSN (Numbers Only)

_____
(DATE OF BIRTH: MM/DD/YYYY)

Injured Worker:

INJURED WORKER'S FIRST NAME
First Name

MI

INJURED WORKER'S LAST NAME
Last Name

INJURED WORKER'S ADDRESS
Address/PO Box (Please leave blank spaces between numbers, names or words)

INJURED WORKER'S CITY
City State Zip Code

Attorney/Representative for Injured Worker:

NAME OF INJURED WORKER'S ATTORNEY
Name

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

ATTORNEY CITY
City State Zip Code

Lien Claimant (Completion of this section is required):

NAME OF ORGANIZATION FILING LIEN
Name of Organization filing lien (for individual lien claimants, leave blank)

FIRST NAME OF CONTACT
First Name of Individual filing lien(organizational lien claimants, leave blank)

LAST NAME OF CONTACT
Last Name of Individual filing lien(organizational lien claimants, leave blank)

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

ORGANIZATION CITY
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 OR REPRESENTATIVE - USE UNIFORM ASSIGNED NAME

Lien Claimant Law Firm/Representative

REPRESENTATIVE FIRST NAME

First Name

REPRESENTATIVE LAST NAME

Last Name

LAW FIRM OR REPRESENTATIVE ADDRESS

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

LAW FIRM OR REPRESENTATIVE CITY

City State Zip Code

LAW FIRM OR REPRESENTATIVE PHONE

Phone

Employer

NAME OF COMPANY INJURED WORKER WAS WORKING FOR

Name

COMPANY ADDRESS

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

COMPANY CITY

City State Zip Code

Insurance Carrier or Claims Administrator

CLAIMS ADMINISTRATOR - USE UNIFORM ASSIGNED NAME

Name

ADMINISTRATOR ADDRESS

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

ADMINISTRATOR CITY

City State Zip Code

Employer or Claims Administrator Attorney/Representative (if known)

ADMINISTRATOR LAW FIRM - USE UNIFORM ASSIGNED NAME

Name

ADMINISTRATOR LAW FIRM ADDRESS

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

ADMINISTRATOR LAW FIRM CITY

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
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):

SELECT ONE OR MORE REASONS

- ☐ 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.

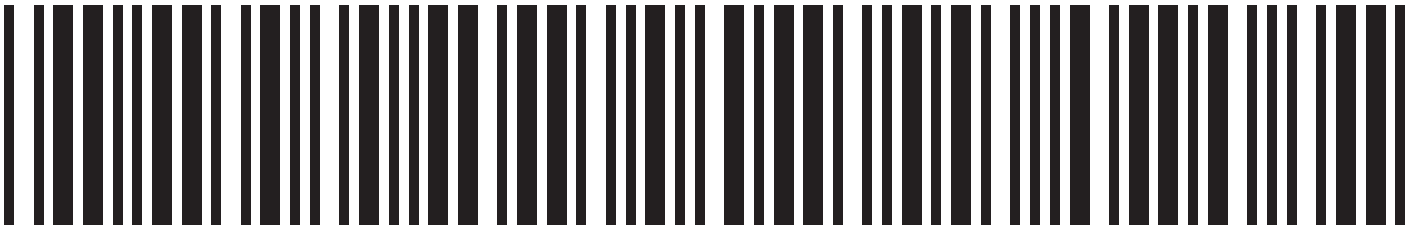
NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

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

TODAY'S DATE

_____	_____	_____
(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 SAMPLE

Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: 10770.5 VERIFICATION

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: IF YOU ARE THE INJURED WORKER, USE YOUR NAME. IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OR LAW FIRM -- USE YOUR UNIFORM ASSGINED NAME.

Office Use Only

Received Date
MM/DD/YYYY

PRINT CLEAR

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.

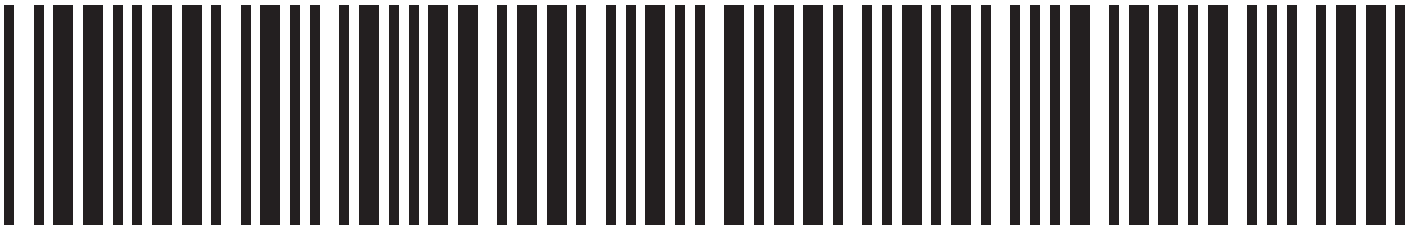
_____ The time provided for payment of medical-legal expenses pursuant to Labor Code section 4622 has elapsed.

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



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SAMPLE

Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

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Author: YOUR NAME

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PRINT CLEAR

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 _____

SAMPLE

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of YOUR COUNTY California. I am over the age of eighteen years, my (business/residence) address is:

PUT YOUR HOME ADDRESS HERE

On TODAY'S DATE, I served the attached NAME OF DOCUMENT on the INSURANCE COMPANY 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 CITY WHERE YOU MAILED THIS 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) TODAY'S DATE, at CITY California.

Type or print name PRINT YOUR NAME

Signature SIGN YOUR NAME