

**STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
WORKERS' COMPENSATION APPEALS BOARD**

V.	APPLICANT
	DEFENDANT(S).

CASE NO. _____

PRE-TRIAL CONFERENCE STATEMENT §5502 (d) (3)
 NOTICE OF HEARING

LOCATION: _____ DATE: _____ TIME: _____

SETTLEMENT CONFERENCE JUDGE: _____

APPEARANCES:

INJURED WORKER: _____

INJURED WORKER'S ATTORNEY _____

 (FIRM NAME AND PERSON APPEARING)

DEFENDANT'S ATTORNEY _____

 (FIRM NAME AND PERSON APPEARING)

OTHERS APPEARING:
 (L.C., INTERPRETERS, ETC.) _____

ADDRESS RECORD CHANGES: _____

ATTY HRG REP

ATTY HRG REP

ATTY HRG REP

ATTY HRG REP

ATTY HRG REP

 (DEFENDANT)

BOX BELOW TO BE COMPLETED ONLY BY WORKERS' COMPENSATION JUDGE

DISPOSITION: SET FOR REGULAR HEARING: WCAB NOTICE NOTICE WAIVED

1 HOUR 2 HOURS 1/2 DAY ALL DAY

BEFORE ANY WCJ BEFORE WCJ _____ BEFORE ANY WCJ OTHER THAN _____

CASE(S) SET ON _____ AT _____ WCJ _____ IN _____

(DATE) (TIME) (LOCATION)

OTHER DISPOSITION AND ORDERS: _____

SERVICE AS ORDERED ON PAGE 4

**WORKERS' COMPENSATION
 ADMINISTRATIVE LAW JUDGE**

STIPULATIONS

THE FOLLOWING FACTS ARE ADMITTED:

1. _____, BORN ____/____/____
 WHILE EMPLOYED ALLEGEDLY EMPLOYED
 ON _____
 DURING THE PERIOD(S) _____

AS A(N) _____, OCCUPATIONAL GROUP NUMBER _____
 AT _____, CALIFORNIA,
 BY _____

SUSTAINED INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT TO _____

CLAIMS TO HAVE SUSTAINED INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT TO _____

2. AT THE TIME OF INJURY THE EMPLOYER'S WORKERS' COMPENSATION CARRIER WAS _____

THE EMPLOYER WAS PERMISSIBLY SELF-INSURED UNINSURED LEGALLY UNINSURED

3. AT THE TIME OF INJURY, THE EMPLOYEE'S EARNINGS WERE \$ _____ PER WEEK, WARRANTING INDEMNITY RATES OF \$ _____ FOR TEMPORARY DISABILITY AND \$ _____ FOR PERMANENT DISABILITY.

4. THE CARRIER/EMPLOYER HAS PAID COMPENSATION AS FOLLOWS: (TD/PD/VRMA)

TYPE	WEEKLY RATE	PERIOD	TYPE	WEEKLY RATE	PERIOD
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

THE EMPLOYEE HAS BEEN ADEQUATELY COMPENSATED FOR ALL PERIODS OF T/D CLAIMED THROUGH _____

5. THE EMPLOYER HAS FURNISHED ALL SOME NO MEDICAL TREATMENT.
 THE PRIMARY TREATING PHYSICIAN IS _____

6. NO ATTORNEY FEES HAVE BEEN PAID AND NO ATTORNEY FEE ARRANGEMENTS HAVE BEEN MADE.

7. OTHER STIPULATIONS _____

 APPLICANT

 DEFENDANT

 LIEN CLAIMANT/OTHER

ISSUES

- EMPLOYMENT _____
- INSURANCE COVERAGE _____
- INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT _____
- PARTS OF BODY INJURED: _____
- EARNINGS: EMPLOYEE CLAIMS _____ PER WEEK, BASED ON _____
EMPLOYER/CARRIER CLAIMS _____ PER WEEK, BASED ON _____
- TEMPORARY DISABILITY, EMPLOYEE CLAIMING THE FOLLOWING PERIOD(S): _____

- PERMANENT AND STATIONARY DATE:
EMPLOYEE CLAIMS ____/____/____, BASED ON _____
EMPLOYER/CARRIER CLAIMS ____/____/____, BASED ON _____
- PERMANENT DISABILITY APPORTIONMENT
- OCCUPATION AND GROUP NUMBER CLAIMED: BY EMPLOYEE _____
BY EMPLOYER/CARRIER _____
- NEED FOR FURTHER MEDICAL TREATMENT _____
- LIABILITY FOR SELF-PROCURED MEDICAL TREATMENT _____

LIENS:

<u>LIEN CLAIMANT</u>	<u>TYPE OF LIEN</u>	<u>AMOUNT AND PERIODS PAID</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- ATTORNEY FEES
- OTHER ISSUES: _____
- _____
- _____
- _____
- _____

APPLICANT

DEFENDANT

LIEN CLAIMANT/OTHER

PRE-TRIAL CONFERENCE STATEMENT

CASE NO. _____

THIS PAGE FOR JUDGE'S USE ONLY

JUDGE'S CONFERENCE NOTES: _____

ORDERS

IT IS ORDERED PURSUANT TO WCAB RULE 10500, THAT DEFENDANT APPLICANT LIEN CLAIMANT SERVE FORTHWITH THIS PRE-TRIAL CONFERENCE STATEMENT NOTICE OF HEARING ON ALL PARTIES OR THEIR REPRESENTATIVE SHOWN ON THE OFFICIAL ADDRESS RECORD AND ANY ADDITIONAL LIEN CLAIMANTS WHOSE LIENS ARE SHOWN UNDER **ISSUES** (PAGE 3).

IT IS FURTHER ORDERED THAT DEFENDANT APPLICANT LIEN CLAIMANT SERVE TIMELY NOTICE OF THE TIME AND PLACE OF ALL REGULAR HEARING SESSIONS ON ALL LIEN CLAIMANTS WHOSE LIENS ARE SHOWN UNDER ISSUES, TOGETHER WITH THE **FOLLOWING NOTICE: YOUR LIEN IS AT ISSUE AND WILL BE ADJUDICATED AT REGULAR HEARING.**

IT IS FURTHER ORDERED THAT THE PROOF OF SERVICE ORDERED ABOVE BE FILED WITH THE WCAB **ONLY** ON REQUEST OF THE ASSIGNED WORKERS' COMPENSATION JUDGE.

OTHER DISPOSITION AND ORDERS

SERVICE OF THIS DOCUMENT WAS MADE PERSONALLY UPON _____ BY WCJ.

DATE ____ / ____ / ____

**WORKERS' COMPENSATION
ADMINISTRATIVE LAW JUDGE**

1. APPLICANT, BORN _____, SUSTAINED OR CLAIMS INJURY AS FOLLOWS:

	(1)	(2)	(3)	(4)
CASE NO.				
DOI				
	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>
BODY PARTS				
JOB TITLE(S) OCCUPATIONAL GROUP NO(S).				
EARNINGS & TD/PD RATES				
EMPLOYER				
CARRIER ADJUSTED BY				
WORK COMP SECURED BY	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>
COVERAGE DATES				

2. THE CARRIER/EMPLOYER HAS PAID COMPENSATION AS FOLLOWS:

<u>TYPE</u>	<u>WEEKLY RATE</u>	<u>PERIOD</u>	<u>PAID BY</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. THE EMPLOYEE HAS BEEN ADEQUATELY COMPENSATED FOR ALL PERIODS OF TEMPORARY DISABILITY CLAIMED THROUGH _____.

4. THE EMPLOYER HAS FURNISHED ALL SOME NO MEDICAL TREATMENT.
THE PRIMARY TREATING PHYSICIAN IS _____.

5. NO ATTORNEY FEES HAVE BEEN PAID AND NO ATTORNEY FEE AGREEMENTS HAVE BEEN MADE.

6. OTHER STIPULATIONS: _____

