

This packet contains instructions on how to fill in Optical Character Recognition (OCR) forms, examples of forms and is in the order in which forms / documents should be filed with the district office.

Use the table below to help identify the forms that you need to complete when filing an amended application for adjudication of claim. The table also shows the order in which the forms should be assembled. To help you find the correct document separator sheet, the product delivery unit, document type and document title are in brackets.

In this packet, you will see examples as filed by applicant attorney for injured worker.

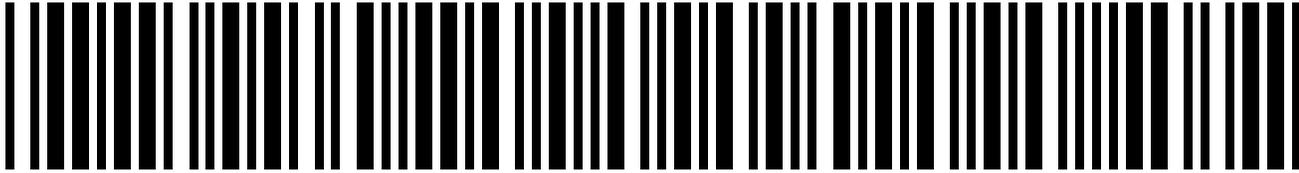
Name of form	
1	Document cover sheet
2	Document separator sheet [ADJ-LEGAL DOCS-APPLICATION FOR ADJUDICATION]
3	Check the box for amended application on the upper right page of the application for adjudication of claim - may include addendum
4	Proof of service

This packet is an example of how to fill in forms and the order in which they should be filed with the district office.

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

01/07/2010
Date:(MM/DD/YYYY)

SSN: _____

Specific Injury

ADJ123456
Case Number 1

Cumulative Injury (Start Date: MM/DD/YYYY) 11/02/2007 (End Date: MM/DD/YYYY)

as the specific date of injury)

ENTER THE CASE NUMBER.

ENTER THE DATE OF INJURY. IF CUMULATIVE INJURY, MUST ENTER START AND END DATE USING MM/DD/YYYY FORMAT.

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 VOC INT RSU

Companion Cases

DO NOT LIST COMPANION CASES. YOU MAY AMEND ONLY ONE APPLICATION AT A TIME.

Specific Injury

Case Number 2

Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Example

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: _____

Do NOT print or submit blank pages.

Example

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.

DO NOT PRINT OR
SUBMIT THIS PAGE.

Body Part Code List

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

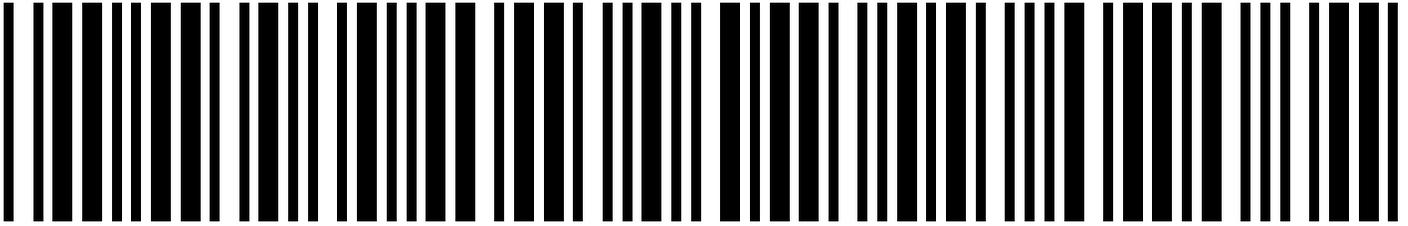
100	Head - not specified	500	Lower extremities - not specified
110	Brain	510	Legs - above ankles, not specified
120	Ear - not specified	511	Thigh femur
121	Ear - external	513	Knee Patella
124	Ear - internal including hearing	515	Lower leg tibia and fibula
130	Eye - including optic nerves and vision	518	Leg - multiple parts any combination of above parts
140	Face - not specified	519	Leg - not specified
141	Jaw - including chin and mandible	520	Ankle malleolus
144	Mouth - including lips, tongue, throat and taste	530	Foot not ankle or toe
145	Teeth	540	Toes
146	Nose - including nasal passages, sinus and smell	598	Lower extremities - multiple parts any combination of above parts
148	Face - multiple parts any combination of above parts	700	Multiple parts more than five major parts use only in fifth position of listing of body parts
149	Face - forehead, cheeks, eyelids	800	Body system - not specific
150	Scalp	801	Circulatory system - heart -other than heart attack, blood, arteries,veins, etc.
160	Skull	802	Circulatory system - Heart attack
198	Head - multiple injury any combination of above parts	810	Digestive system - stomach
200	Neck	820	Excretory system - kidneys, bladder, intestines, etc.
300	Upper extremities - not specified	830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
310	Arm - above wrist not specified	840	Nervous system - not specified
311	Arm - upper arm humerus	841	Nervous system - stress
313	Arm - elbow head of radius	842	Nervous system - Psychiatric/psych
315	Arm -forearm radius and ulna	850	Respiratory system - lungs, trachea, etc.
318	Arm - multiple parts any combination of above parts	860	Skin dermatitis, etc.
319	Arm - not specified	870	Reproductive systems
320	Wrist	880	Other body systems
330	Hand - not wrist or fingers	999	Unclassified - insufficient information to identify body parts
340	Fingers		
398	Upper extremities - multiple parts any combination of above parts		
400	Trunk - not specified		
410	Abdomen - including internal organs and groin		
411	Hernia		
420	Back - including back muscles, spine and spinal cord		
430	Chest - including ribs, breast bone and internal organs of the chest		
440	Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks		
450	Shoulders - scapula and clavicle		
498	Trunk - use for side; multiple parts any combination of above parts		

Do NOT print or submit this page.

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

Example

DOCUMENT SEPARATOR SHEET



Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title AMENDED APPLICATION FOR ADJUDICATION

Document Date 12/01/2009 Enter date of Amended Application.
MM/DD/YYYY

Author UNIFORM ASSIGNED NAME

If you are a claims administrator or representative, use your Uniform Assigned Name. All others, enter your name.

Office Use Only

Received Date _____
MM/DD/YYYY

Example



**STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM**



ENTER THE CASE NUMBER TO WHICH YOU ARE AMENDING.

ADJ123456
Case No.

Amended Application

CHECK THE BOX FOR AMENDED APPLICATION.

SSN (Numbers Only)

Venue choice is based upon (Completion of this section is required)

- County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

VNO

3 DIGIT OFFICE CODE MUST BE IN COUNTY OF BOX CHECKED ABOVE.

Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Injured Worker (Completion of this section is required)

JOHN
First Name MI

MILLER
Last Name

1234 WILLOW ROAD
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

VAN NUYS CA 91401
City State Zip Code

Applicant (If other than Injured Worker)

- Insurance Carrier
- Employer
- Lien Claimant

Name (Please leave blank spaces)

USE THE UNIFORM ASSIGNED NAME AND ADDRESS FOR ATTORNEY OR THE CLAIMS ADMINISTRATOR, IF YOU ARE AN INSURANCE CARRIER. USE YOUR NAME AND ADDRESS, IF YOU ARE AN EMPLOYER OR A LIEN CLAIMANT.

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer Information (Completion of this section is required)

MUST CHECK ONE BOX.

Insured

Self-Insured

Legally Uninsured

Uninsured

COMPANY INJURED EMPLOYEE WORKED FOR AT TIME OF INJURY.

Employer Name (Please leave blank spaces between numbers, names or words)

COMPANY ADDRESS - MUST INCLUDE STREET ADDRESS OR PO BOX NUMBER.

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

MUST INCLUDE CITY, STATE AND ZIP CODE.

City

State

Zip Code

Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)

NAME OF EMPLOYER'S INSURANCE CARRIER.

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

INSURANCE CARRIER'S ADDRESS - MUST INCLUDE STREET ADDRESS OR PO BOX NUMBER.

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

MUST INCLUDE CITY, STATE AND ZIP CODE.

City

State

Zip Code

Claims Administrator Information (If known and if applicable)

ENTER UNIFORM ASSIGNED NAME OF CLAIMS ADMINISTRATOR.

Name (Please leave blank spaces between numbers, names or words)

CLAIMS ADMINISTRATOR ADDRESS - MUST USE THE ONE IN UAN DATABASE.

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

CLAIMS ADMINISTRATOR IS A SELF-ADMINISTERED INSURER, A SELF ADMINISTERED SELF-INSURED EMPLOYER, A SELF-ADMINISTERED JOINT POWERS AUTHORITY, A SELF-ADMINISTERED LEGALLY UNINSURED OR A THIRD PARTY ADMINISTRATOR.

MUST INCLUDE CITY, STATE AND ZIP CODE.

City

State

Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born **MUST INCLUDE INJURED EMPLOYEE'S DATE OF BIRTH.**, while employed as a(n) **ENTER JOB TITLE WHEN INJURED.**
(DATE OF BIRTH: MM/DD/YYYY) (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

specific injury (Date of injury: MM/DD/YYYY)

INJURY DATE/S MUST MATCH DATE/S INDICATED ON DOCUMENT COVER SHEET.

suffered a :

cumulative injury which began on (Start Date: MM/DD/YYYY) and ended on (End Date: MM/DD/YYYY)

The injury occurred at

MAY PUT "ON JOB SITE" OR COMPLETE ADDRESS WHERE INJURY OCCURED.

Street Address/PO Box - Please leave blank spaces between numbers, names or words

MUST INCLUDE CITY AND ZIPCODE. USE "CA" FOR STATE.

City

State

Zip Code

(State which parts of the body were injured)

Body Part 1: 430 CHEST

Body Part 2: 100 HEAD

Body Part 3:

Body Part 4:

Other Body Parts:

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

ADDING BODY PART 430 AND DELETING BODY PART 420.

ENTER THE ITEM(S) YOU WANT TO AMEND IN THIS SECTION. YOU MAY ALSO SUBMIT THE ITEM(S) TO BE AMENDED IN AN ADDENDUM.

3. Actual earnings at the time of injury:

Rate of Pay \$ _____ Monthly Weekly Hourly State value of tips, meals, lodging, or other advantages, regularly received \$ _____ Monthly Weekly Hourly

Number of hours worked per week _____

DO NOT ENTER NONE, UNKNOWN OR N/A. IF YOU DON'T HAVE INFORMATION, LEAVE BLANK.

4. The injury caused disability as follows:

Last day off work due to injury: _____ MM/DD/YYYY

First Period of Disability: Start Date _____ MM/DD/YYYY End Date _____ MM/DD/YYYY

Second Period of Disability: Start Date _____ MM/DD/YYYY End Date _____ MM/DD/YYYY

5. Compensation:

Compensation was paid: Yes No

Total paid: _____

Weekly rate(s): _____

Date of last payment: _____ MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury? Yes No

7. Medical treatment:

Medical treatment was received:

Yes No

All treatment was furnished by the Employer or Insurance Carrier:

Yes No

Date of last treatment: _____
MM/DD/YYYY

Other treatment was provided/paid by: _____
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim?

Yes No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

Case Number 1

Case Number 3

Case Number 2

Case Number 4

9. This application is filed because of a disagreement regarding liability for:

MUST SELECT AT LEAST ONE.

- | | |
|--|---|
| <input type="checkbox"/> Temporary disability indemnity | <input type="checkbox"/> Permanent disability indemnity |
| <input type="checkbox"/> Reimbursement for medical expense | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Medical treatment | <input type="checkbox"/> Supplemental Job Displacement/Return to Work |
| <input type="checkbox"/> Compensation at proper rate | <input type="checkbox"/> Other (Specify) _____ |

Is the Applicant Represented? Yes No If "No", applicant is to sign and date below.

If "Yes", applicant's representative is to complete the following and is to sign and date below.

Law Firm/Attorney Non-Attorney Representative

ENTER UNIFORM ASSIGNED NAME OF LAW FIRM.

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name MI

Attorney/Representative Last Name

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

City State Zip Code

ATTORNEY SIGNS HERE.

Applicant Attorney/Representative Signature

Applicant Signature

Dated at VAN NUYS City, California

Date 12/01/2009 MM/DD/YYYY

ENTER THE SAME DATE AS THE DOCUMENT SEPARATOR SHEET.

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS IS A PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendant(s) named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney's fee will be set by the Workers' Compensation Appeals Board at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

For "amended" applications, the venue choice must be the same as that specified on the original application, unless an order changing venue has issued. A street or P.O. Box address within the United States must be entered for the place where the injury occurred. Therefore, if the injury did not occur at a fixed or identifiable location (such as a field, a highway, or on water), or if the injury occurred outside of the United States, the employer's business address or another appropriate address must be specified; however, a short explanation regarding the place of injury may be appended to the application. If medical treatment has been paid for by Medi-Cal, Medicare, group health insurance, or a private carrier, please specify.

Service of Documents

Your attorney or agent will serve all documents in accordance with Labor Code section 5501 and the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file a Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the district office of the Workers' Compensation Appeals Board, or by calling the district office and requesting this form.



Proof of Service

I am at least 18 years of age, not a party to this action, and I am a resident of or employed in the county where the mailing took place.

My business address is: 

On 12/01/2009 served a true copy of the following documents, along with supporting documents, described as: Amended application of adjudication of claim by enclosing them in a sealed envelope addressed to each of the parties named and at the addresses set forth in the Party List, and placing each envelope for collection and mailing at the business address herein following our ordinary business practices, with postage fully prepaid, or by other previously agreed-upon method of electronic service.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: 12/01/2009

Declarant Signature 

Party List



Example