

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

Use the table below to help identify the forms that you need to complete when filing a declaration of readiness to proceed. 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 the applicant attorney for injured worker. If a lien claimant is filing the forms, then complete and submit the documents identified in this reference table.

	Name of form	Applicant attorney for injured worker	Claims administrator and/or defense attorney	Lien claimant
1	Document cover sheet	х	Х	х
2	Document separator sheet [ADJ-LEGAL DOCS-DECLARATION OF DEADINESS TO PROCEED]			
3	READINESS TO PROCEED]	X	Х	Х
_	Declaration of readiness to proceed	x	x	x
4	Document separator sheet for medical report [ADJ-MEDICAL DOCS- ALL MEDICAL REPORTS or AME REPORTS			
	or QME REPORTS]	х	Х	
5	Medical report	х	х	
6	Document separator sheet for lien verification [ADJ-LEGAL DOCS – 10770.6 VERIFICATION]			x
7	Lien verification §10770.6			х
8	Document separator sheet for supporting documents. [ADJ-MISC – CORRESPONDENCE OTHER] If an appropriate document title is available, use it.			x
9	Lien supporting documents			x
10	Document separator sheet for proof of service [ADJ-LEGAL DOCS-PROOF OF SERVICE]	x	x	x
11	Proof of service	х	Х	x

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 CALIFORN DWC DISTRICT OFFIC DOCUMENT COVER SH	CE       This example shows documents submitted by a represented injured worker.         HEET
Is this a new case? Yes	No       ✓       Companion Cases Exist         TO BE SET ALONG       WITH MASTER CASE.	Walkthrough YesNo✓
More than 15 Companion Cases          09/10/2008       DATE YOU FILL OU         Date:(MM/DD/YYYY)	T DOCUMENT COVER SHEET.	SOCIAL SECURITY NUMBER IS NOT SSN: REQUIRED.
ADJ12345 Case Number 1	Cumulative Injury (Start Date: MM/E	DD/YYYY) (End Date: MM/DD/YYYY) jury, use the start date as the specific date of injury)
Body Part 1:	NO OTHER INFORMATION IS NEEDED WHEN CORRECT CASE NUMBER	Body Part 3:
Body Part 2:	IS LISTED.	Body Part 4:
Other Body Parts:		
Please check unit to be filed on ( cl	heck only one box )	
ADJ DEU	SIF UEF	
Companion Cases       WHEN CORI         CASE NUME       LISTED, IT IS         ADJ67890       COMPLETE         Case Number 2       INFORMATION	BER IS S NOT Y TO OTHER ON. umulative Injury (Start Date: MM/D	
Body Part 1:	(If Specific Inju	rry, use the start date as the specific date of injury) Body Part 3:
Body Part 2:		Body Part 4:
Other Body Parts: DWC-CA form 10232.1 Rev. 7/2010	) - Page 1 of 8	Example

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	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	Do NOT print or submit blank page.
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:		
DWC-CA form 1023	2.1 Rev. 11/2008- Page 2 of 8	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 Djego
SFO	San Francisco
SJO	San Jose
SLO	San Luis Obispo
SRO	Santa Rosa
STK	Stockton
VNO	Van Nuys
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Use this document to complete forms, but do not file this document with your forms.





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#### 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         121       Ear - not specified       511       Thigh femur         121       Ear - internal including bearing       513       Lower leg tibia and floba         130       Eye - including optic nerves and vision       518       Leg - multiple parts any combination of above parts         141       Jaw including bips, tongue, throat and taste       520       Ankle malleolus         144       Mouth - including nasal passages, sinus and smell       540       Toes         145       Face - including nasal passages, sinus and smell       540       Toes         146       Nose - including nasal passages, sinus and smell       540       Toes         147       Face - forehead, checks, eyelids       700       Multiple parts any combination of above parts         150       Scalp       800       The first of body parts         160       Skull       800       161         171       Head - multiple parts any combination of above parts       800         172       Neck       801       Circulatory system - heart -other than heart attack         173       Arm - ubper art mumerus       820				
120Ear - not specified511Thigh femur121Ear - external513Knee Patella130Eye - including optic nerves and vision518Leg - multiple parts any combination of above parts141Jaw - including thin and mandible518Leg - not specified143Mouth - including lips, tongue, throat and taste530Foot not ankle onlog144Mouth - including nasal passages, sinus and smell510Foot not ankle onlog145Teeth530Foot not ankle onlog146Nose - including nasal passages, sinus and smell540Toes147Face - forchead, checks, eyelids700Multime parts more than five major parts use offs in inflip parts any combination of above parts540149Face - forchead, checks, eyelids700Multime parts more than five major parts use offs in inflip parts more than five major parts use offs in inflip parts more than five major parts use offs in inflip parts any combination of above parts800150Upper extremities - not specified800Digestive system - hoat specified151Arm - elbow head of radius above parts800Back - forchead, enders, bindage and grain above parts153Arm - forearm radius and uha above parts810Musculo-skeletal system - bones, joints, tendons, muscles, etc.154Arm - elbow head of radius above parts840Nervous system - long, trachea, etc.155Arm - forearm radius and uha above parts841Nervous system - long, trachea, etc.166 <td></td> <td>-</td> <td>500</td> <td>Lower extremities - not specified</td>		-	500	Lower extremities - not specified
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<ul> <li>311 Arm - upper arm humerus</li> <li>313 Arm - elbow head of radius</li> <li>315 Arm - forearm radius and ulna</li> <li>316 Arm - multiple parts any combination of above parts</li> <li>319 Arm - not specified</li> <li>320 Wrist</li> <li>330 Hand - not wrist or fingers</li> <li>340 Fingers</li> <li>398 Upper extremities - multiple parts my combination of above parts</li> <li>398 Upper extremities - multiple parts my combination of above parts</li> <li>400 Trunk - not specified</li> <li>410 Abdomen - including internal organs and groin</li> <li>411 Hernia</li> <li>420 Back - including internal organs and groin</li> <li>411 Hernia</li> <li>420 Back - including pelvis, breast bone and internal organs of the chest</li> <li>440 Hips - including pelvis, pelvic organs, tailbone, coccyx and battocks</li> <li>450 Shoulders' scapula and clavicle</li> <li>450 Trunk - use for side; multiple parts any combination</li> </ul>				
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Use this document to complete forms, but do not file this document with your forms.

Exampl

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DVC-CA form 10232.1 Rev. 11/2008 - Page 8 of 8

DOC	JMENT SEPARATOR SHEET
	ADJ
Product Delivery Unit	
Document Type	LEGAL DOCS
Document Title	ADINESS TO PROCEED
Document Date	09/10/2008 DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET
Author	MM/DD/YYYY IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OR LAW FIRM USE YOUR UNIFORM ASSIGNED NAME. FOR UNREPRESENTED INJURED WORKERS AND OTHERS ENTER YOUR NAME.

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**Received Date** 

MM/DD/YYYY





#### STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD DECLARATION OF READINESS TO PROCEED

ADJ12345	ENTER CASE NUMBER 1 FROM THE DOCUMENT COVER SHEET.	NOTICE: Any objection to Declaration of Readiness to ten (10) days after service	o proceed shall be	
Case No.	-			
Applicant				
First Name			MI	
Last Name	VS			
Employer Information				
		1		
Employer Name (Pleas	e leave blank spaces between num	bers, names or words)		
Employer Street Addres	ss/PO Box (Please leave blank spa	ces between numbers, names	s or words)	
City			State	Zip Code
Employee	ignate your role ( <mark>Please Select Onl</mark>		laimant HEA	ECT THE TYPE OF RING THAT YOU WANT instruction sheet for
Declarant requests: (Pla	ease Select Only One)			itions)
Mandatory Settlem		nference Rating MSC		rity Conference
				nty comerence
Lien Conference				
At the present time the	principal issues are: <mark>(Check all that</mark>	apply)		
Compensation Ra	ate Rehabilitation/SJDB	Temporary Disab	ility Self	Procured Medical Treatment
Permanent Disab	,		Disc	overy
Employment	Other		-	
Declarant relies on the	report(s) of:			
Doctors (s)	NAME OF DOCTOR'S REPORT THAT	YOU ARE USING	date	
For more than o	one report attach addendum - include ca	ase number and injured employee	name	MM/DD/YYYY
	e medical reports, including treating physicia been previously filed. A Rating MSC will be nent.			
DWC-CA form 10250.1 Page	1 (Rev. 7/2010)	E	Xa	mple

Declarant states under penalty perjury that he or she is presently ready to proceed to hearing on the issues below an	d
has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed below:	

LIST THE EFFORTS MADE TO RESOLVE THE DISPUTE

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and that all medical reports in my possession or control have been filed and served as required by the rules promulgated by the Court Administrator.

Copies of this Declaration have been served this date as shown on the attached proof of service.

Declarant's Signature	YOUR SIGNATURE. Declarant's Signature
ENTER THE UNIFORM ASSIGNED NAME OF THE LA	W FIRM.
Name of declarant or name of the law firm of the declara	ant (Print or Type)
ENTER THE MAILING ADDRESS.	
Address (Please leave blank spaces between numbers,	names or words)
ENTER PHONE NUMBER.	/ DOCUMENT DATE ON DOCUMENT SEPARATOR SHEET.
Phone Number	MM/DD/YYYY

Phone Number



#### INSTRUCTIONS

1. This Declaration must be completed and filed before any case will be set for hearing at the request of any party. A party may request a mandatory settlement conference hearing, status conference hearing, rating mandatory settlement conference hearing, or a priority conference hearing.

**A mandatory settlement conference** is held to assist the parties in resolving the dispute. If the dispute cannot be resolved at that time, the parties should be ready to frame issues, record stipulations, list exhibits, and list the witnesses who will testify at trial. A trial is set only at the discretion of the judge and is set for the purpose of receiving evidence.

A rating mandatory settlement conference is a mandatory settlement conference but ratings of the medical reports will be available at the time of the conference.

A status conference is not a mandatory settlement conference but a proceeding for which judicial attention is required. It can include, but is not limited to, a lien conference or conference in a complicated case in which discovery is not complete and **the** parties need the judge's guidance.

A priority conference is a conference held under Labor Code section 5502(c) in which the injured worker is represented by an attorney and the issues include employment and/or injury arising out of and in the course of employment.

2. Unless notified otherwise, no witness other than the applicant need attend conference hearings. Claims adjusters and lien claimants must be present or available by telephone.

3. The party requiring an interpreter must arrange for the presence of an interpreter, except that the defendant(s) must arrange for the presence of the interpreter if the injured worker is not represented by an attorney.

4. Continuances are not favored and none will be granted after the filing of this Declaration without a clear and timely showing of good cause.

5. The Workers' Compensation Appeals Board favors the presentation of medical evidence in the form of written reports.

6. The WCJ, upon the receipt of the Declaration of Readiness, may set the case for a type of proceeding other than the one requested (Section 10417).

Workers' Compensation Information and Assistance - 1 (800) 736-7401

DC	OCUMENT SE	PARATOR SH	EET

Product Delivery Unit	ADJ	
Document Type	MEDICAL DOCS	

Document Title ALL MEDICAL REPORTS

Document Date	09/29/2006	ENTER DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET.
		EXAMPLE:
		JOHN A SMITH MD
		JOHN A SMITH PT
		USE ONLY CAPITAL LETTERS AND NO
Author	MEDICAL PROVIDER NAME	<pre>SPECIAL CHARACTERS E.G. / \ " , " , : ; ( ) &amp; !</pre>

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#### Examination date: August 28, 2006

Page 1 of 5







Patient: Date of birth: **Employer**: Date of Injury: Claim number:



Date of examination: August 28, 2006 Date of report: September 29, 2006

Dear

Thank you for asking me to examine for hand surgery consultation.

#### Chief complaint:

right thumb base pain

#### History:

right handed woman. At the time of her injury she was employed as a espresso bar barista by the She had store in worked there beginning about

She presents a 4 page history of her right thumb pain. She states that in 1999 she had the gradual onset of right thumb base pain. She reported this in 1999, and was initially treated at Occupational Medicine Associates in San Leandro. "They told me I had arthritis". Treatment included ibuprofen splinting and therapy treatment. "I never got better". She continued at the espresso bar for another year or two, and then the department was closed. She left Nordstrom for about a year, and worked "freelance"

## Example

Examination date: August 28, 2006

Page 2 of 5

drafting and other work.

Patient

She then returned to **provide the set of the** 

She returned to the worker's comp system, and was treated at Concentra beginning in August 2005. She had additional medication, got another splint, and had therapy at Concentra and Cornerstone. There was temporary improvement with therapy for a couple of days.

In February 2006, she saw for what sounds like evaluation. She is not sure what the result of the evaluation was.

Symptoms have not improved. The patient currently complains of right thumb base pain with pinching, such as a clothespin pinch. The pains occur everyday with activities of daily living, episodes can last "all night long". Using a Q tip hurts. Hair care hurts. The symptoms are relieved by rest, or "plurging my hand in a bucket of ice". Ibuprofen helps the pain also for a few hours. She denies numbness, tingling in the right or left, and there are no left hand symptoms.

She has remained at work. She now works doing freelance drafting.

is now seen for hand surgery consultation.

#### Past Medical History:

Prior history of upper extremity complaints or injuries; none Ongoing medical conditions; none Prior surgery; gallbladder 2000, tonsils in childhood Current medications; none Allergies to medications; A causes GI irritation Tobacco use; none Alcohol use; none Regular primary physician; Kaiser

#### Family and Social History:

Single, no children. She has a cat. She does some drawing for pleasure. She walks for exercise. She does not participate in any sports.

Exampl

**Review of systems:** 

Patient

Examination date: August 28, 2006

Page 3 of 5

The patient has had visual "floaters". She has ringing in the ears with aspirin. She denies ongoing symptoms of headache, hearing loss, persistent sore throat, shortness of breath, chest pain, abnormal cough, abdominal pain, blood or burning with urination, blood in bowel movements, menstrual disorders, current pregnancy, or unexplained weight loss.

Records reviewed: (9/29/2006, 15 minutes)

Four-page letter from the patient, setting forth in great detail her duties as a barista, the medical course, the symptoms. Also detailing work as a sales associate.

52 page file of records

4/27/2006, panel QME report Diagnosis chronic right thumb tendinitis. Permanent and stationary "at least by October 1, 2005". Future medical treatment includes hand therapy, Dr. visits three or four times a year. Night splints. Medication.

Records from Concentra medical center.

9/14/2005, radial styloid tenosynovitis, resolved. Arthritis, right thumb carpal metacarpal and metacarpal phalangeal, non-industrial. Released from care at maximum medical improvement, no permanent disability.

9/2/2005, right hand metacarpal pharyngeal tenosynovitis. Medication, therapy, activity modification.

8/24/2005, physical therapy visits.

8/19/2005, doctors first report,

Reports from Occupational Medicine Associates,

4/8/1999, right thumb arthritis. Regular work beginning 4/8/1999.

3/23/1999, right thumb arthritis.

Physical therapy notes, from 3/10/1999 to 3/23/1999.

3/8/1999, doctors first report, sector right thumb overuse and arthritis. Use splints.

Physical examination:

weight.

Example

#### Examination date: August 28, 2006

On record review, I note the diagnosis by the more recent treaters and on the QME report was tenosynovitis and chronic thumb tendonitis. Thumb CMC arthritis is an age related condition, which can be aggravated by work exposure. There may be need to ask for QME re evaluation regarding apportionment of the thumb CMC arthritis, which appears to be the ongoing condition.

The nature of the condition was discussed. Treatment options were discussed, and include activity modification, ergonomic changes, medication, splinting, therapy, steroid injection, and ultimately surgery. In fact, she has had all of these except for injection and surgery. She has had non specialist physical therapy splinting, but had not had hand therapy or custom thumb CMC splinting. Symptoms persist, and now impact daily living activities.

I advised a limited course of therapy, with focus on teaching activity modification, and custom short oppenens splinting.

She is scheduled for follow up October 9, 2006. Further treatment might be needed, based upon her symptoms.

I hereby declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report are true to the best of my information and belief. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that *information*, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true. In compliance with Labor Code Section 5703 (A)(1), I, Kendrick E. Lee, the consulting physician, declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration whether in the form of money or otherwise as compensation or inducement for any referred examination or evaluation.

Signed September 29, 2006 in Alameda County, California.



# Example

Patient

DOCL	JMENT SEPARATOR SHEET
Product Delivery Unit	ADJ
Document Type	LEGAL DOCS
Document Title	
Document Date	09/10/2008 DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET MM/DD/YYYY

Author

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UNIFORM ASSIGNED NAME

**Received Date** 

MM/DD/YYYY



ADMINISTRATOR, HEARING REPRESENTATIVE OR LAW FIRM USE YOUR UNIFORM

ASSIGNED NAME. FOR UNREPRESENTED INJURED WORKERS AND OTHERS ENTER YOUR NAME.

3	PROOF OF SERVICE
4	I certify and declare as follows:
5	I am over the age of 18 years, and not a party to the within
-	
7	
8	which is located in the county where the
9	mailing described below took place. On the date listed below, I served
	the following documents: Declaration of Readiness to Proceed, and
1	Driginal Medical Reports (see attached list) by placing a true copy
2	thereof enclosed in a sealed enveloped and served in the manner and/or
	manners described below to each of the parties herein and addressed as
4	stated below:
5	X United States Postal Service, U.S. Mail, with First Class
5	postage prepaid and deposited in sealed envelope at Oakland,
7	California. I am readily familiar with the business practice at my place of business for collection and processing of
8	correspondence for mailing with the United States Postal Service. Correspondence so collected and processed is
9	deposited with the U.S. Postal Service that same day in the ordinary course of business.
0	D Facsimile Transmission
	Hand-Delivery:
2	Hand-Dellvery:
3	
4	
5	
5	I certify and declare under penalty of perjury under the laws of
	the State of California that the foregoing is true and correct.
	Executed on 9/10/08