

How to file an application for adjudication of claim

Complete this form if you have a disagreement with your employer or its insurance company about your case and you want it resolved by your local Workers' Compensation Appeals Board (WCAB). Filing this form opens a case with the WCAB.

You can also complete this form if you think you may need the WCAB to resolve a dispute in the future and the time allowed for you to file the application could run out. If you have questions about whether time limits apply in your case, contact your local Information and Assistance office. You can get information on contacting a local I&A office on the Web at www.dwc.ca.gov.

Complete the form and follow the instructions attached. This form can also be completed at <https://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWC1.pdf>.

Please note that a hearing in your case will not be scheduled until a declaration of readiness to proceed is filed (see I&A guide 5).

The following papers must be included with your completed application:

1. A copy of your claim for workers' compensation benefits (required only for injuries that happened between 1-1-90 and 12-31-93). See I&A guide 1.
2. Declaration required by law (Labor Code section 4906(h) -- see attached). A proof of service is recommended. See attached.

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 Application for Adjudication of Claim*)
- ✓ [Application for Adjudication of Claim](#)
- ✓ [Document Separator Sheet](#) (*for Proof Of Service By Mail*)
- ✓ [Proof Of Service By Mail](#)
- ✓ [Document Separator Sheet](#) (*for Declaration Pursuant to Labor Code Section 4906(h)*)
- ✓ [Declaration Pursuant to Labor Code Section 4906\(h\)](#)

Keep copies of your filings for your records.

Information & Assistance Unit guide 4

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 https://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.dwc.ca.gov.

If you do not have the name and address of your claims administrator to complete a form, please link to <https://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 forms handbook for further instructions.

WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

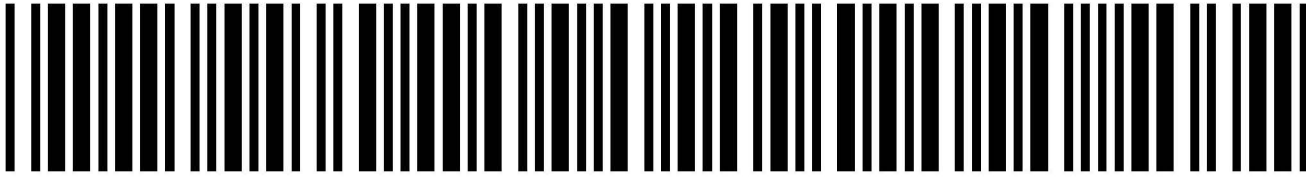
- **ANAHEIM, 92806-2131**
1065 North Link, Suite 170
Information & Assistance Unit **(714) 414-1801**
- **BAKERSFIELD, 93301-1929**
1800 30th Street, Suite 100
Information & Assistance Unit **(661) 395-2514**
- **FRESNO, 93721-2219**
2550 Mariposa Street, Suite 4078
Information & Assistance Unit **(559) 445-5355**
- **LODI, 95240-6936**
3021 Reynolds Ranch Parkway, Suite 130
Information & Assistance Unit **(209) 948-7759**
- **LONG BEACH, 90810-1870**
1500 Hughes Way, Suite C203
Information & Assistance Unit **(424) 450-2565**
- **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) 482-3820**
- **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 Floor, Suite 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 Unit **(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, 95110-3718**
224 Airport Parkway, Suite 600
Information & Assistance Unit **(408) 277-1292**
- **SAN LUIS OBISPO, 93401-8736**
4740 Allene Way, Suite 100
Information & Assistance Unit **(805) 596-4159**
- **SANTA ANA, 92707-7704**
2 MacArthur Place, Suite 600
Information & Assistance Unit **(714) 942-7576**
- **SANTA BARBARA, 93101-7538**
130 E Ortega Street
Information & Assistance Unit **(805) 568-1390**
- **SANTA ROSA, 95404-4771**
50 "D" Street, Suite 420
Information & Assistance Unit **(707) 576-2452**
- **VAN NUYS, 91401-3370**
6150 Van Nuys Boulevard, Suite 105
Information & Assistance Unit **(818) 901-5374**



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**

EAMS CASE NUMBER

Case Number 1

☐ Specific Injury

DATE OF INJURY

☐ 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)

**IF NEW CASE
LEAVE BLANK**

Body Part 1:

**USE CODE FROM
BODY PART CODE LIST --
SEE PAGE 8**

Body Part 3:

Body Part 2:

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 ☐ SAU ☐ 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 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 |
| FRE | Fresno |
| LAO | Los Angeles |
| LBO | Long Beach |
| LOD | Lodi |
| MDR | Marina del Rey |
| OAK | Oakland |
| OXN | Oxnard |
| POM | Pomona |
| RDG | Redding |
| RIV | Riverside |
| SAC | Sacramento |
| SAL | Salinas |
| SBA | Santa Barbara |
| SBR | San Bernardino |
| SDO | San Diego |
| SFO | San Francisco |
| SJO | San Jose |
| SLO | San Luis Obispo |
| SRO | Santa Rosa |
| VNO | Van Nuys |

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

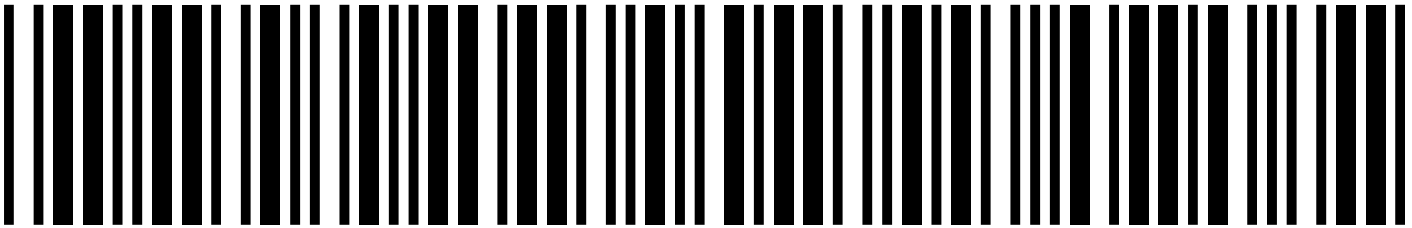
BODY PART CODES LIST

| Code Number | Description |
|-------------|---|
| 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 |

| Code Number | Description |
|-------------|---|
| 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 |
| 900 | COVID-19 |
| 999 | Unclassified - insufficient information to identify body parts |

SAMPLE

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

APPLICATION FOR ADJUDICATION

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

YOUR NAME

Office Use Only

Received Date

MM/DD/YYYY



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

SAMPLE

LEAVE BLANK

☐ Amended Application

Case No. _____

YOUR SOCIAL SECURITY NUMBER

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).)



SELECT ONE

**USE 3 LETTER OFFICE CODE FROM
DOCUMENT COVER SHEET**

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

Injured Worker (Completion of this section is required)

YOUR FIRST NAME

First Name _____

MI _____

YOUR LAST NAME

Last Name _____

YOUR MAILING ADDRESS

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)

YOUR CITY

City _____

State _____

Zip Code _____

Applicant (If other than Injured Worker)

- ☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

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

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)

SAMPLE

☐

Insured

☐

Self-Insured

☐

Legally Uninsured

☐

Uninsured

☐

NAME OF COMPANY YOU WERE WORKING FOR AT TIME OF INJURY

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

COMPANY ADDRESS

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

COMPANY CITY

City

State

Zip Code

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

NAME OF COMPANY INSURANCE CARRIER

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

INSURANCE CARRIER ADDRESS

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

INSURANCE CARRIER CITY

City

State

Zip Code

Claims Administrator Information (If known and if applicable)

NAME OF CLAIMS ADMINISTRATOR

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

CLAIMS ADMINISTRATOR ADDRESS

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

CLAIMS ADMINISTRATOR CITY

City

State

Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born

YOUR BIRTH DATE

(DATE OF BIRTH: MM/DD/YYYY)

, while employed as a(n)

YOUR JOB TITLE WHEN INJURED

(OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

☐

specific injury

DATE OF ACCIDENT

(Date of injury: MM/DD/YYYY)

suffered a :

☐

cumulative injury

which began on

(Start Date: MM/DD/YYYY)

and ended on

(End Date: MM/DD/YYYY)

The injury occurred at

ADDRESS WHERE ACCIDENT TOOK PLACE

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

City

State

Zip Code

(State which parts of the body were injured)

SAMPLE

Body Part 1:

**PART OF BODY THAT WAS INJURED, USE LIST
FROM DOCUMENT COVER SHEET**

Body Part 2:

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)

INDICATE WHAT YOU WERE DOING AT THE TIME OF INJURY

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

4. The injury caused disability as follows:

Last day off work due to injury:

LAST DAY WORKED

MM/DD/YYYY

First Period of Disability:

Start Date

FIRST DAY OFF WORK

MM/DD/YYYY

End Date

DATE RETURNED

TO WORK

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):

FROM CLAIMS ADMINISTRATOR

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

**IF YOU OR PRIVATE INSURANCE PAID
FOR MEDICAL TREATMENT**

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:

LIST ANY OTHER CASES FILED WITH DWC

Case Number 1

Case Number 3

Case Number 2

Case Number 4

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

- ☐ Temporary disability indemnity
- ☐ Reimbursement for medical expense
- ☐ Medical treatment
- ☐ Compensation at proper rate

- ☐ Permanent disability indemnity
- ☐ Rehabilitation
- ☐ Supplemental Job Displacement/Return to Work
- ☐ Other (Specify) _____

SAMPLE

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

SAMPLE

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

☐ Law Firm/Attorney ☐ Non-Attorney Representative

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

YOUR SIGNATURE

Applicant Attorney/Representative Signature

Applicant Signature

Dated at _____, California
City

Date **TODAY'S DATE**
MM/DD/YYYY

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

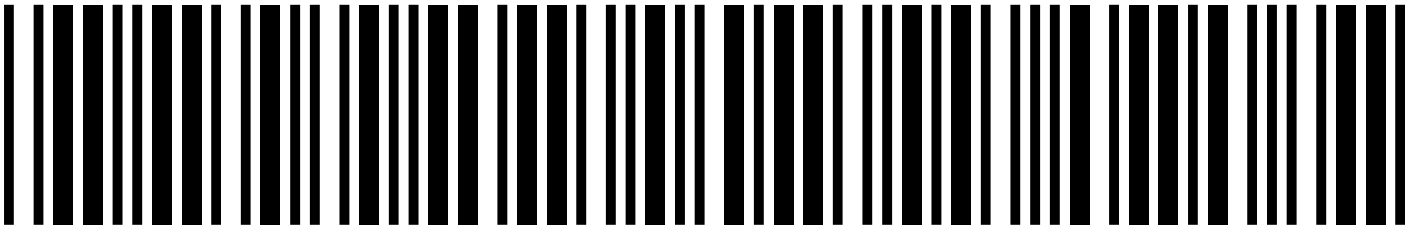
Your attorney or agent will serve all documents in accordance with Labor Code section 5501 and the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

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.

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

PROOF OF SERVICE

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

YOUR NAME

Office Use Only

Received Date

MM/DD/YYYY

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 parties listed below 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:

- 1) WORKERS' COMPENSATION APPEALS BOARD: ADDRESS
- 2) INSURANCE COMPANY: NAME, ADDRESS AND CLAIM NUMBER
- 3) DEFENSE ATTORNEY (IF KNOWN): NAME AND ADDRESS
- 4) ALL OTHER PARTIES INVOLVED IN YOUR CASE: NAME AND ADDRESS

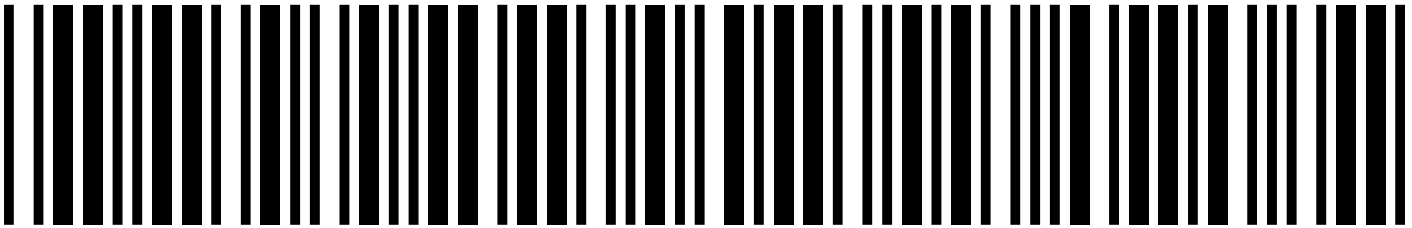
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) TODAY'S DATE, at CITY, California.

Type or print name PRINT YOUR NAME

Signature SIGN YOUR NAME

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

4906(h) DECLARATION

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

YOUR NAME

Office Use Only

Received Date

MM/DD/YYYY

DECLARATION PURSUANT TO LABOR CODE SECTION 4906(h)

Pursuant to Labor Code Section 4906(h), I declare under penalty of perjury that I have not violated Section 139.3 and 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.

Date: _____

TODAY'S DATE

YOUR SIGNATURE

Signature

Before signing this form, you should be aware that: “Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers’ compensation benefits or payments is guilty of a felony.”