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 an 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 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.

<table>
<thead>
<tr>
<th>Name of form</th>
<th>Applicant attorney for injured worker</th>
<th>Claims administrator and/or defense attorney</th>
<th>Lien claimant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Document cover sheet</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>2 Document separator sheet</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>3 Application for adjudication of claim</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>4 Document separator sheet for labor code section 4906(g) [ADJ-LEGAL DOCS-4906(g) DECLARATION]</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>5 All declarations pursuant to labor code section 4906(g)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>6 Document separator sheet for fee disclosure statement [ADJ-LEGAL DOCS-FEE DISCLOSURE STATEMENT]</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Fee disclosure statement</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Document separator sheet for venue authorization [ADJ-LEGAL DOCS-VENUE VERIFICATION]</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>9 Venue authorization</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Document separator sheet for lien verification [ADJ-LEGAL DOCS-10770.5 VERIFICATION]</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>11 Lien verification §10770.5</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>12 Document separator sheet for proof of service [ADJ-LEGAL DOCS-PROOF OF SERVICE]</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>13 Proof of service</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
This packet is an example of how to fill in forms and the order in which they should be filed with the district office.

This example shows documents submitted by a represented injured worker.

### Document Cover Sheet

- **Is this a new case?** Yes [✓] No
- **Companion Cases Exist** [ ]
- **Walkthrough** Yes [ ] No [ ]
- **More than 15 Companion Cases** [ ]

**Date:** 09/10/2008

**Social Security Number:**

**Case Number 1**

- **Body Part 1:** 420
- **Body Part 2:** 100
- **Other Body Parts:**

**Case Number 2**

- **Body Part 1:**
- **Body Part 2:**
- **Other Body Parts:**

**Date:** 11/02/2007

**Start Date:** MM/DD/YYYY

**End Date:** MM/DD/YYYY

**Specific Injury**

**Cumulative Injury**

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

**If Cumulative Injury must enter start and end date using MM/DD/YYYY.**

**Body Part Number 700 in This Field**

**See Body Part Number List on Page 8**

**Please check unit to be filed on (check only one box)**

- [ ] ADJ
- [ ] DEU
- [ ] SIF
- [ ] UEF
- [ ] INT
- [ ] RSU

**Companion Cases**

- **Specific Injury**

- **Case Number 2**

- **Body Part 1:**
- **Body Part 2:**

**Other Body Parts:**
Case Number 3

Body Part 1: ____________________________
Body Part 2: ____________________________
Other Body Parts: ____________________________

Case Number 4

Body Part 1: ____________________________
Body Part 2: ____________________________
Other Body Parts: ____________________________

Case Number 5

Body Part 1: ____________________________
Body Part 2: ____________________________
Other Body Parts: ____________________________
### District office codes for place of venue

<table>
<thead>
<tr>
<th>Legend</th>
<th>Abbreviation</th>
<th>Office</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AHM</td>
<td>Anaheim</td>
</tr>
<tr>
<td></td>
<td>ANA</td>
<td>Santa Ana</td>
</tr>
<tr>
<td></td>
<td>BAK</td>
<td>Bakersfield</td>
</tr>
<tr>
<td></td>
<td>EUR</td>
<td>Eureka</td>
</tr>
<tr>
<td></td>
<td>FRE</td>
<td>Fresno</td>
</tr>
<tr>
<td></td>
<td>GOL</td>
<td>Goleta</td>
</tr>
<tr>
<td></td>
<td>LAO</td>
<td>Los Angeles</td>
</tr>
<tr>
<td></td>
<td>LBO</td>
<td>Long Beach</td>
</tr>
<tr>
<td></td>
<td>MDR</td>
<td>Marina del Rey</td>
</tr>
<tr>
<td></td>
<td>OAK</td>
<td>Oakland</td>
</tr>
<tr>
<td></td>
<td>OXN</td>
<td>Oxnard</td>
</tr>
<tr>
<td></td>
<td>POM</td>
<td>Pomona</td>
</tr>
<tr>
<td></td>
<td>RDG</td>
<td>Redding</td>
</tr>
<tr>
<td></td>
<td>RIV</td>
<td>Riverside</td>
</tr>
<tr>
<td></td>
<td>SAC</td>
<td>Sacramento</td>
</tr>
<tr>
<td></td>
<td>SAL</td>
<td>Salinas</td>
</tr>
<tr>
<td></td>
<td>SBR</td>
<td>San Bernardino</td>
</tr>
<tr>
<td></td>
<td>SDO</td>
<td>San Diego</td>
</tr>
<tr>
<td></td>
<td>SFO</td>
<td>San Francisco</td>
</tr>
<tr>
<td></td>
<td>SJO</td>
<td>San Jose</td>
</tr>
<tr>
<td></td>
<td>SLO</td>
<td>San Luis Obispo</td>
</tr>
<tr>
<td></td>
<td>SRO</td>
<td>Santa Rosa</td>
</tr>
<tr>
<td></td>
<td>STK</td>
<td>Stockton</td>
</tr>
<tr>
<td></td>
<td>VNO</td>
<td>Van Nuys</td>
</tr>
</tbody>
</table>
## 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.

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

Use this document to complete forms, but do not file this document with your forms.
Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: APPLICATION FOR ADJUDICATION

Document Date: 04/16/2008

Author: UNIFORM ASSIGNED NAME

Received Date: MM/DD/YYYY

IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OFFICE OR LAW FIRM, USE YOUR OFFICE'S UNIFORM ASSIGNED NAME. FOR ALL OTHERS ENTER YOUR NAME.
STATE OF CALIFORNIA
DIVISION OF WORKERS’ COMPENSATION
WORKERS’ COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

Applicant (If other than Injured Worker)

Injured Worker (Completion of this section is required)

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

VNO

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

See page 6 for additional instructions on completing this form.

Injured Worker (Completion of this section is required)

JOHN MILLER

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

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

USE THE UNIFORM ASSIGNED NAME AND ADDRESS FOR 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)

City State Zip Code
MUST CHECK ONE BOX

[ ] Insured
[ ] Self-Insured
[ ] Legally Uninsured
[ ] Uninsured

Employer Information (Completion of this section is required)

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)

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)

MUST INCLUDE CITY, STATE AND ZIP CODE

City __________________________ State ________ Zip Code __________

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born __________________________, while employed as a(n) __________________________ (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)
[ ] specific injury
[ ] cumulative injury

suffered a :

DATE OF ACCIDENT __________________________ (Date of injury: MM/DD/YYYY)

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

(Start Date: MM/DD/YYYY)

and ended on __________________________ (End Date: MM/DD/YYYY)

The injury occurred at __________________________

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

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 __________

DWC/WCAB Form 1A (11/2008) - (Page 2)
4. The injury caused disability as follows:

(State which parts of the body were injured)

Body Part 1: 420 BACK
Body Part 2: 100 HEAD
Body Part 3: 
Body Part 4: 
Other Body Parts:

IF MORE THAN 5 INJURED BODY PARTS, MAY ENTER 700 MULTIPLE IN OTHER BODY PARTS FIELD AND INCLUDE ADDITIONAL BODY PARTS IN SECTION 2.

2. The injury occurred as follows:

(Explain what the worker was doing at the time of injury and how the injury occurred)

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 $ __________

Number of hours worked per week __________

4. The injury caused disability as follows:

Last day off work due to injury: __________

First Period of Disability:

- Start Date __________
- End Date __________

Second Period of Disability:

- Start Date __________
- End Date __________

5. Compensation:

Compensation was paid:

- Yes
- No

Total paid: 

Weekly rate(s): 

Date of last payment: __________

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 2  
Case Number 3  
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) ________________________________  

MUST SELECT AT LEAST ONE.
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

UNIFORM ASSIGNED NAME OF ATTORNEY FOR CLAIMS ADMINISTRATOR, INJURED WORKER OR LIEN CLAIMANT

Law Firm or Company Name (If Applicable)

__________________________________________________________

Law Firm Number (If Applicable)

__________________________________________________________

Attorney/Representative First Name

__________________________________________________________

Attorney/Representative Last Name

__________________________________________________________

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

__________________________________________________________

City

State

Zip Code

MUST INCLUDE SIGNATURE WHEN APPLICANT IS REPRESENTED

Applicant Attorney/Representative Signature

APPLICANT MUST SIGN WHEN NOT REPRESENTED

Applicant Signature

Dated at ____________________________________________, California

Date 04/16/2008

MM/DD/YYYY

DOCUMENT DATE ON 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.
Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: 4906(g) DECLARATION

Document Date: 04/16/2008

Author: UNIFORM ASSIGNED NAME

Received Date: MM/DD/YYYY

(Note: The form includes instructions for entering the date of the document following the separator sheet and for identifying the author as either a claims administrator, hearing representative, or law firm, or for all others to enter their name.)
EMPLOYEE: [Redacted]

EMPLOYER: [Redacted]

CASE NO/DATE OF INJURY: [Redacted]

Pursuant to the requirements set forth in Labor Code §4906(g), I declare as follows:

I have not violated Labor Code §139.3.

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.

A photostatic copy of this declaration shall be as valid as the original.

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

DATED: 4/16/97

DATED: [Redacted]

APPLICANT'S ATTORNEY

Example
STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

FEE DISCLOSURE STATEMENT

If you choose to be represented by an attorney, your attorney's fees will be deducted from your benefits. The fee will be approved by the Workers' Compensation Appeals Board, with consideration given to: (1) responsibility assumed by the attorney; (2) care exercised in representing you; (3) time involved; and, (4) results obtained.

Attorney's fees normally range from 9% to 12% of the benefits awarded. However, a fee of 15% may be charged if the case is complicated and time consuming. If your attorney has also represented you before the Rehabilitation Unit, there may also be a fee allowed for this representation.

There are certain circumstances where your employer (or his/her insurer) may be liable to pay your attorneys' fees. For example, if employer disputes a permanent disability evaluation obtained when you were not represented by an attorney, your employer may be liable for any attorney fees you incur because of the dispute.

If at anytime you no longer wish to be represented by the attorney, you may withdraw from representation by notifying the attorney. If you withdraw from representation, the fee amount found by a workers' compensation judge to be the fair value of any work the attorney did in your case will be deducted from your award.

An Information and Assistance Officer may be able to answer your questions concerning your workers' compensation benefits at no charge to you. He/She may be able to resolve your problems without the need for litigation.

Call this toll-free number: 1-800-736-7401

Employee's Signature
Date: 9/16/08

Employee's Name

Attorney's Signature
Date:

Attorney's Name

Address

Phone No.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of felony.
This is an example of the Document Separator Sheet for Venue Authorization.

Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: VENUE VERIFICATION

Document Date: 04/16/2008

Author: JOHN SMITH

Received Date: MM/DD/YYYY

Office Use Only
VENUE AUTHORIZATION

I HEREBY AUTHORIZE MY WORKERS' COMPENSATION CASE(S) FOR INJURY(IES)

DATED: ________________ TO BE

FILED AT THE ________________

WORKERS' COMPENSATION APPEALS BOARD.

DATED: 4/16/2008

Applicant's Attorney:

[Redacted]

Drive, Suite

CA

TEL: (____)_______

FAX: (____)_______

APPLICANT
Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: PROOF OF SERVICE

Document Date: 04/16/2008

Author: UNIFORM ASSIGNED NAME

Received Date: MM/DD/YYYY

Office Use Only:

If you are a claims administrator, hearing representative or law firm, use your office's uniform assigned name. For all others, enter your name.

Example
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: [Redacted]

On 04/16/2008 served a true copy of the following documents, along with supporting documents, described as: Application of adjudication of claim, 4906(g), fee disclosure statement and venue authorization 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: 04/16/2008

Declarant Signature [Redacted]

Party List [Redacted]