Declaration of Readiness to Proceed
OCR form sample packet

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	x	x	x
2	Document separator sheet **[ADJ-LEGAL DOCS-DECLARATION OF READINESS TO PROCEED]**	x	x	x
3	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]**	x	x	
5	Medical report	x	x	
6	Document separator sheet for lien verification **[ADJ-LEGAL DOCS – 10770.6 VERIFICATION]**			x
7	Lien verification §10770.6			x
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	x	x	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 CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

This example shows documents submitted by a represented injured worker.

Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☑

TO BE SET ALONG WITH MASTER CASE.

More than 15 Companion Cases ☐

09/10/2008
Date:(MM/DD/YYYY)

DATE YOU FILL OUT DOCUMENT COVER SHEET.

SSN:

SOCIAL SECURITY NUMBER IS NOT REQUIRED.

☐ Specific Injury

ADJ12345
Case Number 1

☐ 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: ________

NO OTHER INFORMATION IS NEEDED WHEN CORRECT CASE NUMBER IS LISTED.

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 ☐ INT ☐ RSU

Companion Cases

WHEN CORRECT CASE NUMBER IS LISTED, IT IS NOT NECESSARY TO COMPLETE OTHER INFORMATION.

pecific Injury

ADJ67890
Case Number 2

umulative 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 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:

Do NOT print or submit blank page.

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:

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
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
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
999	Unclassified - insufficient information to identify body parts

Do NOT print or submit this page.

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

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: DECLARATION OF READINESS TO PROCEED

Document Date: 09/10/2008 — DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET

MM/DD/YYYY

Author: UNIFORM ASSIGNED NAME — 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.

Office Use Only

Received Date

MM/DD/YYYY

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

ENTER CASE NUMBER 1 FROM THE DOCUMENT COVER SHEET.

ADJ12345

Case No.

NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration.

Applicant

First Name ______ MI ______

Last Name ______

VS

Employer Information

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

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

City ______ State ______ Zip Code ______

Declarants: Please designate your role (Please Select Only One)

☐ Employee ☐ Applicant ☐ Defendant ☐ Lien Claimant

SELECT THE TYPE OF HEARING THAT YOU WANT (See instruction sheet for definitions)

Declarant requests: (Please Select Only One)

☐ Mandatory Settlement Conference ☐ Status Conference ☐ Rating MSC* ☐ Priority Conference

☐ Lien Conference

At the present time the principal issues are: (Check all that apply)

☐ Compensation Rate ☐ Rehabilitation/SJDB ☐ Temporary Disability ☐ Self-Procured Medical Treatment

☐ Permanent Disability ☐ Future Medical Treatment ☐ AOE/COE ☐ Discovery

☐ Employment ☐ Other ______

Declarant relies on the report(s) of:

Doctors (s) NAME OF DOCTOR'S REPORT THAT YOU ARE USING ______ date ______

For more than one report attach addendum - include case number and injured employee name

MM/DD/YYYY

*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

Declarant states under penalty perjury that he or she is presently ready to proceed to hearing on the issues below and 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. ______________________________

ENTER THE UNIFORM ASSIGNED NAME OF THE LAW FIRM.

Name of declarant or name of the law firm of the declarant (Print or Type)

ENTER THE MAILING ADDRESS.

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

ENTER PHONE NUMBER.

Phone Number

Date 09/16/2008 DOCUMENT DATE ON DOCUMENT SEPARATOR SHEET.

MM/DD/YYYY

DWC-CA form 10250.1

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

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type MEDICAL DOCS

Document Title ALL MEDICAL REPORTS

Document Date 09/29/2006
MM/DD/YYYY

ENTER DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET.

EXAMPLE:
JOHN A SMITH MD
JOHN A SMITH PT
USE ONLY CAPITAL LETTERS AND NO SPECIAL CHARACTERS E.G. / \ " , " , : ; ( ) & !

Author MEDICAL PROVIDER NAME

Office Use Only

Received Date ____________________
MM/DD/YYYY

8A

[redacted]

Hand Surgery Consultation Report

[redacted]

Patient: [redacted]
Date of birth: [redacted]
Employer: [redacted]
Date of Injury: [redacted]
Claim number: [redacted]
Date of examination: August 28, 2006
Date of report: September 29, 2006

Dear [redacted]

Thank you for asking me to examine [redacted] for hand surgery consultation.

Chief complaint:
right thumb base pain

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

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" drafting and other work.

She then returned to [redacted] working in the men's department beginning about 2002 or 2003. The symptoms persisted. She was subsequently treated at Kaiser for plantar fasciitis. She also asked about her hand and she was told about tendonitis, and she was told that that was work related.

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 [redacted] 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 "plunging 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.

[redacted] 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; ASA 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.

Review of systems:

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 [redacted] 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.[redacted]

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

8/24/2005, physical therapy visits.

8/19/2005, doctors first report,[redacted]

8/19/2005, [redacted]eQuervain's tenosynovitis, thumb spica splint, ibuprofen, modified duty.

Reports from Occupational Medicine Associates,[redacted]
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,[redacted]right thumb overuse and arthritis. Use splints.

Physical examination:
[redacted]ppears her stated 5 foot 4 1/2 inch height and [redacted]weight.

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.

Sincerely,

[redacted]

[redacted]

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title PROOF OF SERVICE

Document Date 09/10/2008

MM/DD/YYYY

DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET

Author UNIFORM ASSIGNED NAME

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.

Office Use Only

Received Date

MM/DD/YYYY

Case Name: [redacted]
Case No.: [redacted]
Our File No.: [redacted]

PROOF OF SERVICE

I certify and declare as follows:

I am over the age of 18 years, and not a party to the within action. My business address is [redacted] which is located in the county where the mailing described below took place. On the date listed below, I served the following documents: **Declaration of Readiness to Proceed, and Original Medical Reports (see attached list)** by placing a true copy 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 stated below:

X United States Postal Service, U.S. Mail, with First Class postage prepaid and deposited in sealed envelope at Oakland, California. I am readily familiar with the business practice at my place of business for collection and processing of correspondence for mailing with the United States Postal Service. Correspondence so collected and processed is deposited with the U.S. Postal Service that same day in the ordinary course of business.

☐ Facsimile Transmission

Hand-Delivery:

[redacted]

[redacted]

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 [redacted]