

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.

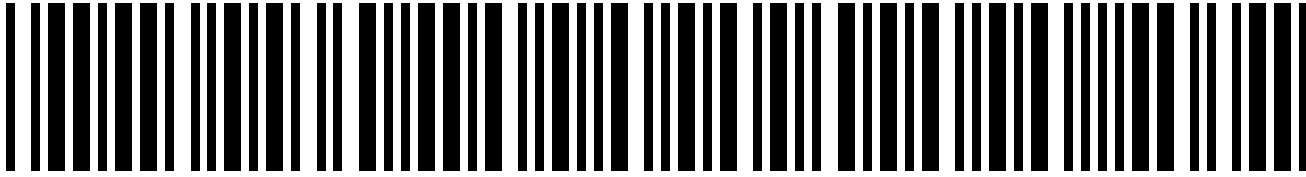
	Name of form	Applicant attorney for injured worker	Claims administrator and/or defense attorney	Lien claimant
1	Document cover sheet	x	x	x
2	Document separator sheet [ADJ-LEGAL DOCS-DECLARATION OF READINESS TO PROCEED]	x	x	x
3	Declaration of readiness to proceed	x	x	x
4	Document separator sheet for medical 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

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

TO BE SET ALONG WITH MASTER CASE.

09/10/2008

DATE YOU FILL OUT DOCUMENT COVER SHEET.

Date:(MM/DD/YYYY)

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

ADJ67890

Case Number 2

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

Specific 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)

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 page.

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.

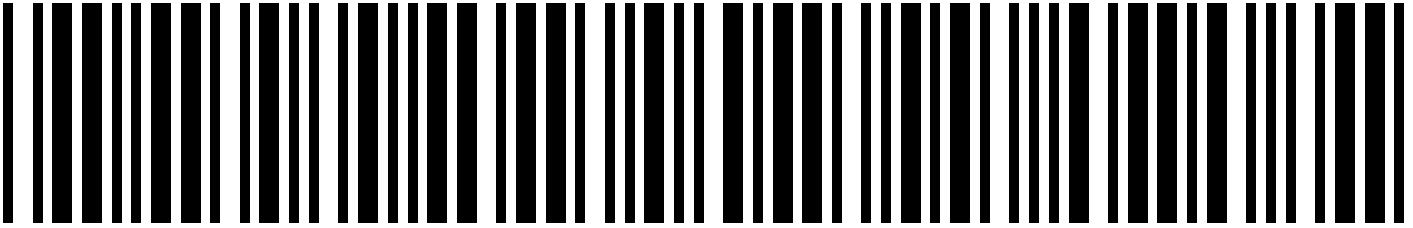
100	Head - not specified	500	Lower extremities - not specified
110	Brain	510	Legs - above ankles, not specified
120	Ear - not specified	511	Thigh femur
121	Ear - external	513	Knee Patella
124	Ear - internal including hearing	515	Lower leg tibia and fibula
130	Eye - including optic nerves and vision	518	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 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.

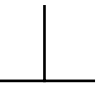
Office Use Only

Received Date _____
MM/DD/YYYY

Example



**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.**

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.

ADJ12345

Case No.

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.



Example
DWC-CA form 10250.1

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

MM/DD/YYYY

DOCUMENT DATE ON DOCUMENT SEPARATOR SHEET.

Example

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.**

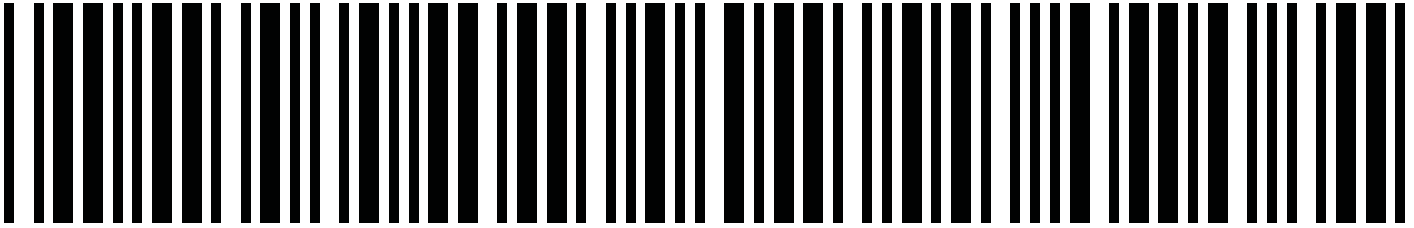
3. The party requiring an interpreter must arrange for the presence of an interpreter, except that the defendant(s) must arrange for the presence of the interpreter if the injured worker is not represented by an attorney.

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).

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.

Author MEDICAL PROVIDER NAME

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

Office Use Only

Received Date _____
MM/DD/YYYY

Example

JA

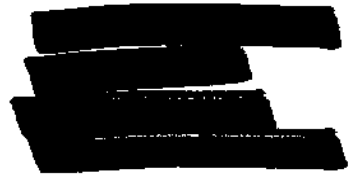
Patient: [REDACTED]

Examination date: August 28, 2006

Page 1 of 5



Hand Surgery Consultation Report



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"

Example

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:

Example

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] deQuervain'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] appears her stated 5 foot 4 1/2 inch height and [REDACTED] weight.

Example

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 opponens splinting.

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

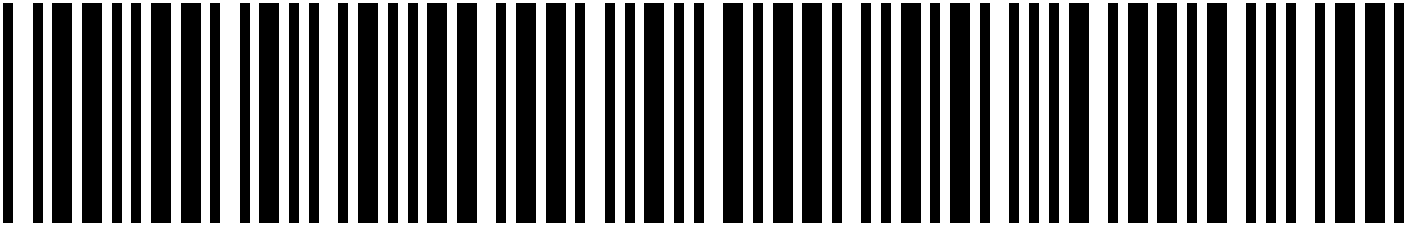
I hereby declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report are true to the best of my information and belief. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and 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]

Example

DOCUMENT SEPARATOR SHEET



Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title PROOF OF SERVICE

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

Example

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]
[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 envelope and served in the manner and/or
manners described below to each of the parties herein and addressed as
stated below:

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]
[REDACTED] [REDACTED]
[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]