

STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD STIPULATIONS WITH REQUEST FOR AWARD

		Date of Injury		
Case No.			MM/DD/YYYY	
SSN (Numbers Only	<u>/)</u>			
Venue Choice is ba	used upon: (Completion of th	nis section is required)		
County of reside	nce of employee (Labor Code	section 5501.5(a)(1) or (d).)		
County where in	jury occurred (Labor Code sec	ction 5501.5(a)(2) or (d).)		
County of princip	oal place of business of emplo	yee's attorney (Labor Code sectior	1 5501.5(a)(3) or (d	l).)
Select 3 Letter Office	e Code For Place/Venue of He	earing (From the Document Cover S	Sheet)	
Applicant (Complet	tion of this section is require	ed)		
First Name			MI	
Last Name			_	
Address/PO Box (P	lease leave blank spaces betw	veen numbers, names or words)		
City			State	Zip Code
Employer #1 Inform	nation (Completion of this se	ection is required)		
Insured	Self-Insured	Legally Uninsured	Uninsu	red
Employer Name (Pl	ease leave blank spaces betw	een numbers, names or words)		
Employer Street Ad		lank spaces between numbers, na	mes or words)	
	diessif O Dox (Flease leave b	iank spaces between numbers, na	mes or words)	
City			State	Zip Code

			justed by claims administrator
Incurance ("arrier Intermation	lit known and it annlicable	- incluido ovon it carrior le ad	illetod by claime administrator

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)		— +
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or	words)	
City	State	Zip Code
Claims Administrator Information (if known and if applicable)		
Name (Please leave blank spaces between numbers, names or words)		
Street Address/PO Box (Please leave blank spaces between numbers, names or words)		
City	State	Zip Code
Employer #2 Information (Completion of this section is required)		
Insured Self-Insured Legally Uninsured	Unins	ured
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
Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrat	or)	
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)		
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or	words)	
City		Zip Code

Name (Please leav	e blank spaces between num	bers, names or words)		
Street Address/PO	Box (Please leave blank space	ces between numbers, names or wo	rds)	
City			State	Zip Code
mployer #3 Inform	nation (Completion of this s	ection is required)		
Insured	Self-Insured	Legally Uninsured	Uninsu	ured
Employer Name (P	lease leave blank spaces bet	ween numbers, names or words)		
Employer Street Ac	ddress/PO Box (Please leave	blank spaces between numbers, na	mes or words)	
nsurance Carrier		rrier is adjusted by claims admini	State	Zip Code
nsurance Carrier I if known and if ap	plicable - include even if ca	rrier is adjusted by claims admini	strator)	Zip Code
Insurance Carrier N	plicable - include even if ca Name (Please leave blank spa		strator) ords)	Zip Code
nsurance Carrier I if known and if ap Insurance Carrier N	plicable - include even if ca Name (Please leave blank spa	ices between numbers, names or wo	strator) ords)	Zip Code
nsurance Carrier I if known and if ap Insurance Carrier N Insurance Carrier Str	plicable - include even if ca Name (Please leave blank spa	ices between numbers, names or wo	strator) ords) es or words)	
nsurance Carrier I if known and if ap Insurance Carrier N Insurance Carrier Str City Claims Administra	p licable - include even if ca Name (Please leave blank spa eet Address/PO Box (Please leav	ices between numbers, names or wo	strator) ords) es or words)	
nsurance Carrier I if known and if ap Insurance Carrier N Insurance Carrier Stru- City Claims Administra Name (Please leav	Plicable - include even if ca Name (Please leave blank spa eet Address/PO Box (Please leave ntor Information (if known ar	ices between numbers, names or wo	strator) ords) es or words) State	
nsurance Carrier I if known and if ap Insurance Carrier N Insurance Carrier Stru- City Claims Administra Name (Please leav	Plicable - include even if ca Name (Please leave blank spa eet Address/PO Box (Please leave ntor Information (if known ar	ices between numbers, names or wo ve blank spaces between numbers, nam nd if applicable) bers, names or words)	strator) ords) es or words) State	

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Employer #4 Inform	ation (Completion of this s	ection is required)		
Insured	Self-Insured	Legally Uninsured		sured
Employer Name (Ple	ease leave blank spaces bet	ween numbers, names or words)		
Employer Street Ado	dress/PO Box (Please leave	blank spaces between numbers, na	mes or words)	
City Insurance Carrier Ir (if known and if app		rrier is adjusted by claims admini	State	Zip Code
Insurance Carrier Nam	ne (Please leave blank spaces b	etween numbers, names or words)		
Insurance Carrier Stree	et Address/PO Box (Please leav	/e blank spaces between numbers, nam	nes or words)	
City Claims Administrate	or Information (if known ar	nd if applicable)	State	Zip Code
	lank spaces between numbers,			
Street Address/PO Bo	X (Please leave blank spaces be	etween numbers, names or words)		
City			State	Zip Code
requirements of Labo 1 Employees First N	or Code section 5313: Name	Award and/or Order, based upon th		, and waive the
Employees Last N			,	
birth date	MM/DD/YYYY	- ,		
while employed at				,, State
as a(n)		Occupation		, ir Group
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More than 4 Compar	nion Cases	
—	Specific Injury	
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:	Body Part 2:	Body Part 3:
Body Part 4:	Other Body Parts:	
	Specific Injury	
Case Number 2	Cumulative Injury	(Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)
Body Part 1:	Body Part 2:	Body Part 3:
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 2:	Body Part 3:
Body Part 4:	Other Body Parts:	
	Specific Injury	
Case Number 4	Cumulative Injury	(Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)
Body Part 1:	Body Part 2:	Body Part 3:
Body Part 4:	Other Body Parts:	
by the employer(s) and th		ustained injury(ies) arising out of and in the course of employment to
	· · · ·	l body parts injured)
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2. The injury (ies) caused temporary d	isability for the period _	MI	t	hrough
fo	r which indemnity has be	en paid at \$	pe Indemnity Paid	r week.
2(a).The injury(ies) caused additional t	temporary disability for th	e period	MM/DD/YYYY	
through	at the rate of \$		in the amount of \$	
MM/DD/YYYY		Rate		Indemnity Paid
3. The injury(ies) caused permanent d	isability of	% for wh	ich indemnity is payable	e at \$ Indemnity Rate
per week beginning	in the	e sum of \$, less ci	redit for such payments
previously made. And a life per	nsion of \$ Life Pension	per week	thereafter.	
6. Applicant's attorney requests a fee o	of \$			
Fees to be commuted as follows:				
7. Liens Against compensation are pa	yable as follows:			

8.Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

9.Other	stipu	lations:
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Dated MM/DD/YYYY	Applicant	
Applicant's Attorney or Authorized Representative:		
Law Firm/Attorney		
First Name		
Last Name		
Firm Number		
Law Firm name		
Address/PO Box (Please leave blank spaces between numbers, names or words)		-
City	State	Zip Code
Dated MM/DD/YYYY	Applicant Attorney Sig	nature
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Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
First Name			I
Last Name			
F ' A1 1			
Firm Number			
Law Firm Name			
Address/PO Box (Please leave blank spaces between numbers, names or words)			
Address/FO Box (Flease leave blank spaces between numbers, names of words)			
City	State	Zip Code	
Dated			
	Defense Attorney	Signature	
Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
First Name			
Filst Name			
Last Name			
Time Number			
Firm Number			
Law Firm Name			
Address /DO Bay (Disses loove blank angess between numbers, names or words)			
Address/PO Box (Please leave blank spaces between numbers, names or words)			
City	State	Zip Code	
Detect			
Dated			
	Defense Attorne	ev Signature	
+		,	

Defendant's Attorney or Authorized Representative:				
Law Firm/Attorney Non Attorney Representative				+
First Name				I
Last Name				
Firm Number				
Law Firm Name				
Address/PO Box (Please leave blank spaces between numbers, names or wo	rds)			
City		State	Zip Code	
Dated	De	efense Attorney	Signature	
Interpreter License Number:				
Interpreter Name		Interpreter Lice	ense Number	

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