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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 On	ly)			
Venue Choice is b	ased upon: (Completion of t	his section is required)		
County of reside	ence of employee (Labor Code	e section 5501.5(a)(1) or (d).)		
County where in	njury occurred (Labor Code se	ection 5501.5(a)(2) or (d).)		
County of princi	ipal place of business of emplo	oyee's attorney (Labor Code section	5501.5(a)(3) or (d).)
Select 3 Letter Office	ce Code For Place/Venue of H	earing (From the Document Cover S	sheet)	
Applicant (Comple	etion of this section is requir	red)		
First Name			MI	
Last Name			-	
Address/PO Box (F	Please leave blank spaces bet	ween numbers, names or words)		
City			State	Zip Code
Employer #1 Inform	mation (Completion of this s	ection is required)		
Insured	Self-Insured	Legally Uninsured	Uninsu	red
Employer Name (P	Please leave blank spaces betw	ween numbers, names or words)		
Employer Street Ac	ddress/PO Box (Please leave I	blank spaces between numbers, nan	nes or words)	_
City			State	Zip Code

surance Carrier Name (Please leave blank spaces between numbers, names or words)		
nsurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, nar	mes or words)	
Dity	State	Zip Code
laims Administrator Information (if known and if applicable)		
lame (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
mployer #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, na	ames or words)	
City	State	Zip Code
nsurance Carrier Information if known and if applicable - include even if carrier is adjusted by claims admin	nistrator)	
Ourien Name (Diagram la control de la contro		
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)		
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, nar	mes or words)	

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

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
mployer #3 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 of	or words)	
City	State	Zip Code
nsurance Carrier Name (Please leave blank spaces between numbers, names or words)		
nsurance 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
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Employer #4 Inform	mation (Completion of this s	section is required)			_
Insured	Self-Insured	Legally Uninsured	Unins	sured	+
Employer Name (P	lease leave blank spaces bet	ween numbers, names or words)			
Employer Street Ad	ddress/PO Box (Please leave	blank spaces between numbers, na	ames or words)		
City Insurance Carrier I (if known and if ap		rrier is adjusted by claims admin	State	Zip Code	
Insurance Carrier Nar	me (Please leave blank spaces b	netween numbers, names or words)			
Insurance Carrier Stre	eet Address/PO Box (Please leav	ve blank spaces between numbers, nan	nes or words)		
City Claims Administra	tor Information (if known ar	nd if applicable)	State	Zip Code	
Name (Please leave b	blank spaces between numbers,	names or words)			
Street Address/PO Bo	ox (Please leave blank spaces be	etween numbers, names or words)			
City			State	Zip Code	
requirements of Lab	oor Code section 5313:	Award and/or Order, based upon th	ne following facts	, and waive the	+
Employees Last	Name		,		
birth date	MM/DD/YYYY	- ,			
while employed at				, -	State
as a(n)		Occupation		, Group	in
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Body Part 1: Body Part 2: Body Part 3: Other Body Parts: Specific Injury (End Date: MM/DD/YYYY) (End Date: MM/D	More than 4 Compa	inion Cases	I
Body Part 2: Body Part 3: Specific Injury Start Date: MM/DD/YYYY (End Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)		Specific Injury	_
Specific Injury ase Number 2	ase Number 1	Cumulative Injury	
Specific Injury ase Number 2 Cumulative Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ody Part 1: Body Part 2: Specific Injury ase Number 3 Cumulative Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ody Part 1: Body Part 2: Body Part 3: Other Body Part 2: Body Part 3: Other Body Parts: Specific Injury ase Number 4 Cumulative Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ase Number 4 Cumulative Injury Other Body Part 2: Body Part 3: Other Body Part 2: Body Part 3: Other Body Part 2: Body Part 3: Other Body Part 3:	ody Part 1:	Body Part 2:	Body Part 3:
ase Number 2 Cumulative Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ody Part 1: Body Part 2: Body Part 3: Other Body Parts: Specific Injury ase Number 3 Cumulative Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ody Part 1: Body Part 2: Body Part 3: Other Body Part 2: Body Part 3: Other Body Parts: Specific Injury ase Number 4 Cumulative Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ody Part 4: Specific Injury Specific Injury Specific Injury, use the start date as the specific date of injury) ody Part 4: Other Body Part 2: Body Part 3: Ody Part 4: Other Body Part 2: Body Part 3: Other Body Part 3:	ody Part 4:	Other Body Parts:	
Body Part 2: Body Part 3:		Specific Injury	
Other Body Parts: Specific Injury ase Number 3 Cumulative Injury Specific Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ody Part 1: Body Part 2: Specific Injury Specific Injury Specific Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ody Part 4: Specific Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ody Part 1: Body Part 2: Body Part 3: Ody Part 4: Other Body Part 2: Body Part 3: Ody Part 4: Other Body Parts:	ase Number 2	Cumulative Injury	
Specific Injury Specific Injury Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)	ody Part 1:	Body Part 2:	Body Part 3:
ase Number 3 Cumulative Injury (Start Date: MM//DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) Dody Part 1: Body Part 2: Dother Body Parts: Specific Injury (Start Date: MM//DD/YYYY) (End Date: MM//DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) Dody Part 4: Body Part 2: Body Part 3: Specific Injury, use the start date as the specific date of injury) Dody Part 1: Body Part 2: Body Part 3: Dody Part 4: Other Body Parts:	ody Part 4:	Other Body Parts:	
ody Part 1: Body Part 2: Body Part 3: Other Body Parts: Specific Injury ase 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) ody Part 1: Body Part 2: Body Part 3:		Specific Injury	
Other Body Parts: Specific Injury ase Number 4 Cumulative Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ody Part 1: Body Part 2: Body Part 3: Other Body Parts:	ase 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)
Specific Injury ase Number 4 Cumulative Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ody Part 1: Body Part 2: Other Body Parts:	ody Part 1:	Body Part 2:	Body Part 3:
ase Number 4 Cumulative Injury (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury) ody Part 1: Body Part 2: Body Part 3: ody Part 4: Other Body Parts:	ody Part 4:	Other Body Parts:	
ody Part 1: Body Part 2: Body Part 3: body Part 4: Other Body Parts:		Specific Injury	
ody Part 4: Other Body Parts:	ase 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)
	ody Part 1:	Body Part 2:	Body Part 3:
	ody Part 4:	Other Body Parts:	
	the employer(s) and the		
		(Please list all	body parts injured)

2. The injury (ies) caused temporary disability for the per	iod through
for which indemnity	has been haid at \$
MM/DD/YYYY	has been paid at \$ per week
2(a). The injury(ies) caused additional temporary disability	y for the period
through at the rate o	f \$ in the amount of \$ Indemnity Paid
The injury(ies) caused permanent disability of	% for which indemnity is payable at \$Indemnity Rate
per week beginning	in the sum of \$, less credit for such payments
previously made. And a life pension of \$	per week thereafter.
Labor Code §4658(d) adjustment:	
Increase rate to \$ as of	
	MM/DD/YYYY
Decrease rate to \$ as of	
as or	MM/DD/YYYY
Not Applicable	
An informal rating has / has not (Select one) be	een previously issued in case no(s)
4.There is is Not a need for medical treatment	to cure or relieve from the effects of said injury (ies).
5. Medical-legal expenses and/or liens are payable by do	efendant as follows:
6. Applicant's attorney requests a fee of \$	
Fees to be commuted as follows:	
7. Liens Against compensation are payable as follows:	
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9.Other stipulations:			
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Dated	Applicant		
	, привани		
Applicant's Attorney or Authorized Representative:			ı
Law Firm/Attorney Non Attorney Representative			+
			'
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	Applicant Attorney Sig	nature	
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8. Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
First Name			
First Name			
Last Name			
Lastinanie			
Firm Number			
Law Firm Name			
Address/PO Box (Please leave blank spaces between numbers, names or words)			
Address/1 & Box (1 lease leave blank spaces between numbers, names of words)			
City	 State	Zip Code	
Oity	State	Zip Code	
Dated			
MM/DD/YYYY ———	Defense Attorney	Signature	
Defendantle Attenness on Asith original Department files	Delense Automey	Signature	
Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
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	
	State	Zip Code	
City Dated MM/DD/YYYY	State	Zip Code	
Dated			
Dated	State Defense Attorne		— — —

Defendant's Attorney or	Authorized Representative:			
Law Firm/Attorney	Non Attorney Representative			
First Name				
Last Name				
Firm Number				
Law Firm Name				
Address/PO Box (Please lea	ave blank spaces between numbers, names or word:	s)		
`	,	,		
City		State	Zip Code	
DatedMM/DD/\				
IVIIVI/DD/	1111	Defense Attorney	Signature	
Interpreter Licence Num	ber:			
Interpreter Nar	me	Interpreter Lice	ense Number	