

State of California
Division of Workers' Compensation
Workers' Compensation Appeals Board
Arbitration Submittal Form

Employee First Name: _____ Middle Initial: _____
Last Name: _____
Address/P.O. Box: _____
City: _____ State: _____ Zip Code: _____

Employee Representative Law Firm /Attorney Non attorney Representative

Law Firm: _____
First Name: _____ Middle Initial: _____
Last Name: _____
Address/P.O.Box: _____
City: _____ State: _____ Zip Code: _____

Is the injured worker requesting arbitration or is the injured worker a party to the arbitration? _____

List all the parties to this request for arbitration in the spaces provided below.

Party Requesting Arbitration (If applicable)

Insurance Co. Self-Insured Legally Uninsured Uninsured Lien Claimant Case number: _____

Party Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Party Representative

Law Firm: _____
First Name: _____ Middle Initial _____
Last Name: _____
Address/P.O.Box: _____
City: _____ State: _____ Zip Code: _____

Party to the Arbitration

Insurance Co. Self-Insured Legally Uninsured Uninsured Lien Claimant Case Number: _____

Party Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Party Representative

Law Firm /Attorney Non attorney Representative

Law Firm: _____

First Name: _____ Middle Initial: _____

Last Name: _____

Address/P.O.Box: _____

City: _____ State: _____ Zip Code: _____

Party to the Arbitration

Insurance Co. Self-Insured Legally Uninsured Uninsured Lien Claimant Case Number: _____

Party Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Party Representative

Law Firm /Attorney Non attorney Representative

Law Firm: _____

First Name: _____ Middle Initial: _____

Last Name: _____

Address/P.O.Box: _____

City: _____ State: _____ Zip Code: _____

Party to the Arbitration

Insurance Co. Self-Insured Legally Uninsured Uninsured Lien Claimant Case Number: _____

Party Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Party Representative

Law Firm /Attorney Non attorney Representative

Law Firm : _____

First Name: _____ Middle Initial: _____

Last Name: _____

Address/P.O.Box: _____

City: _____ State: _____ Zip Code: _____

Party to the Arbitration

Insurance Co. Self-Insured Legally Uninsured Uninsured Lien Claimant Case Number: _____

Party Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Party Representative

Law Firm /Attorney Non attorney Representative

Law Firm: _____

First Name: _____ Middle Initial: _____

Last Name: _____

Address/P.O.Box: _____

City: _____ State: _____ Zip Code: _____

The issues below are hereby submitted for arbitration pursuant to Labor Code section 5275:

Mandatory arbitration under Labor Code section 5275 (a)

Insurance Coverage

Contribution

Voluntary arbitration under Labor Code section 5275 (b)

Explanation of issues submitted for arbitration

The parties have agreed to have this case heard before:

Arbitrator Name _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

The parties have unsuccessfully attempted to agree on a arbitrator and request a list of arbitrators pursuant to Labor Code section 5271(b).

The parties to the arbitration must sign this form in the spaces provides below.

Dated: _____ at _____, _____

Party or party representative: _____

Party or party representative: _____

Party or party representative: _____

Party or party representative: _____

Party or party representative: _____