STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

INFORMATION REQUEST FORM

NOTICE TO INJURED WORKER'S ATTORNEY: This form is to be used when the injured worker is represented by an attorney. The completed form, together with the disclosure form pursuant to Labor Code Section 4906, subdivision (e), and all medical reports and records in the possession of the injured worker should be sent by the attorney to the employer or, if known, to the claims administrator, the insurance carrier, or the third party administrator.

DEMAND: Demand is hereby made for medical records or medical reports pertaining to the injury claimed herein, which medical record or medical reports are in the possession of the employer, insurer or third party administrator, if any.

1) Name, address and Social Security number of employee:
2) Name, address and telephone number of attorney:
3) Date of Injury: _____
   Location of injury: _____
4) Part or parts of body affected by the alleged injury: _____
5) Carrier or third party administrator of the employer, if known:
6) Employee's date of birth: _____
7) Earnings at time of injury: _____
8) Occupation at time of injury: _____
9) Names and address of doctors or hospitals providing medical treatment not provided or paid for by the employer or carrier: _____
   _____
10) Other cases filed for industrial injuries by the employee: _____
    _____

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. Labor Code Section 5401.7.

11) Employee is claiming the following:

- ☐ Temporary disability indemnity
  - ☐ Weekly indemnity rate:
  - ☐ Period(s) claimed:
  - ☐ Other:
- ☐ Permanent disability indemnity
  - ☐ Weekly indemnity rate:
  - ☐ Nature and extent:
  - ☐ Other:
- ☐ Reimbursement for medical expenses
- ☐ Medical treatment
- ☐ Compensation at the proper rate
- ☐ Vocation Rehabilitation
  - ☐ Vocation Rehabilitation temporary disability indemnity
    - ☐ Weekly indemnity rate:

☐ Period(s) claimed:

☐ Vocation Rehabilitation maintenance allowance

☐ Weekly indemnity rate:

☐ Period(s) claimed:

☐ Other issues:

12) The following medical reports, records and other information are being provided herewith:

13) The employee [will] [will not] agree to arbitration pursuant to Part 3.5 (commencing with Labor Code Section 5270).

14) Venue selected by employee if an application for adjudication is filed: _____

(District office location)

If venue is selected based solely on attorney's principal place or business (L.C. §5501.5(a)(3)), check here ☐

NOTICE: Employer has a right to object to the above-selected venue only within 30 days of receipt of the Information Request Form.
NOTICE: The Information Response Form must be served on the employee's attorney within 30 days of receipt of the Information Request Form.
NOTICE: The information furnished by the employee in the Information Response Form and the information furnished in the Information Response Form shall not be admissible in any proceeding before the Workers' Compensation Appeals Board. Item Number 14 on the request form and Item Number 12 on the response form only may be considered in subsequent proceedings involving determinations regarding venue.

Completed by: _____ Date mailed: _____

(Signature)