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 an application for adjudication of claim. 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.

<table>
<thead>
<tr>
<th>Name of form</th>
<th>Applicant attorney for injured worker</th>
<th>Claims administrator and/or defense attorney</th>
<th>Lien claimant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Document cover sheet</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>2 Document separator sheet</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Application for adjudication of claim</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>4 Document separator sheet for labor code section 4906(g) [ADJ-LEGAL DOCS-4906(g) DECLARATION]</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>5 All declarations pursuant to labor code section 4906(g)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>6 Document separator sheet for fee disclosure statement [ADJ-LEGAL DOCS-FEE DISCLOSURE STATEMENT]</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Fee disclosure statement</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Document separator sheet for venue authorization [ADJ-LEGAL DOCS-VENUE VERIFICATION]</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Venue authorization</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Document separator sheet for lien verification [ADJ-LEGAL DOCS-10770.5 VERIFICATION]</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>11 Lien verification §10770.5</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Document separator sheet for proof of service [ADJ-LEGAL DOCS-PROOF OF SERVICE]</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>13 Proof of service</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
This packet is an example of how to fill in forms and the order in which they should be filed with the district office.

This example shows documents submitted by a represented injured worker.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☑ No ☐

Companion Cases Exist ☐ Walkthrough Yes ☐ No ☐

More than 15 Companion Cases ☐

09/10/2008 DATE YOU FILL OUT DOCUMENT COVER SHEET

SSN: SOCIAL SECURITY NUMBER IS NOT REQUIRED.

Date:(MM/DD/YYYY)

THERE IS NO CASE NUMBER FOR APPLICATION FOR ADJUDICATION LEAVE BLANK.

Case Number 1

☐ 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)

IF CUMULATIVE INJURY MUST ENTER START AND END DATE USING MM/DD/YYYY.

SEE BODY PART NUMBER LIST ON PAGE 8

Body Part 1: 420 ☐ Body Part 3: ☐

Body Part 2: 100 ☐ Body Part 4: ☐

OTHER BODY PARTS: WHEN MORE THAN 5 BODY PARTS USE BODY PART NUMBER 700 IN THIS FIELD

Please check unit to be filed on (check only one box)

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

Case Number 2

☐ 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: ☐

DWC-CA form 10232.1 Rev. 7/2010 - Page 1 of 8

Example
District office codes for place of venue

<table>
<thead>
<tr>
<th>Legend</th>
<th>Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbreviation</td>
<td>Office</td>
</tr>
<tr>
<td>AHM</td>
<td>Anaheim</td>
</tr>
<tr>
<td>ANA</td>
<td>Santa Ana</td>
</tr>
<tr>
<td>BAK</td>
<td>Bakersfield</td>
</tr>
<tr>
<td>EUR</td>
<td>Eureka</td>
</tr>
<tr>
<td>FRE</td>
<td>Fresno</td>
</tr>
<tr>
<td>GOL</td>
<td>Goleta</td>
</tr>
<tr>
<td>LAO</td>
<td>Los Angeles</td>
</tr>
<tr>
<td>LBO</td>
<td>Long Beach</td>
</tr>
<tr>
<td>MDR</td>
<td>Marina del Rey</td>
</tr>
<tr>
<td>OAK</td>
<td>Oakland</td>
</tr>
<tr>
<td>OXN</td>
<td>Oxnard</td>
</tr>
<tr>
<td>POM</td>
<td>Pomona</td>
</tr>
<tr>
<td>RDG</td>
<td>Redding</td>
</tr>
<tr>
<td>RIV</td>
<td>Riverside</td>
</tr>
<tr>
<td>SAC</td>
<td>Sacramento</td>
</tr>
<tr>
<td>SAL</td>
<td>Salinas</td>
</tr>
<tr>
<td>SBR</td>
<td>San Bernardino</td>
</tr>
<tr>
<td>SDO</td>
<td>San Diego</td>
</tr>
<tr>
<td>SFO</td>
<td>San Francisco</td>
</tr>
<tr>
<td>SJO</td>
<td>San Jose</td>
</tr>
<tr>
<td>SLO</td>
<td>San Luis Obispo</td>
</tr>
<tr>
<td>SRO</td>
<td>Santa Rosa</td>
</tr>
<tr>
<td>STK</td>
<td>Stockton</td>
</tr>
<tr>
<td>VNO</td>
<td>Van Nuys</td>
</tr>
</tbody>
</table>

Use this document to complete forms, but do not file this document with your forms.
# 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Head - not specified</td>
</tr>
<tr>
<td>110</td>
<td>Brain</td>
</tr>
<tr>
<td>120</td>
<td>Ear - not specified</td>
</tr>
<tr>
<td>121</td>
<td>Ear - external</td>
</tr>
<tr>
<td>124</td>
<td>Ear - internal including hearing</td>
</tr>
<tr>
<td>130</td>
<td>Eye - including optic nerves and vision</td>
</tr>
<tr>
<td>140</td>
<td>Face - not specified</td>
</tr>
<tr>
<td>141</td>
<td>Jaw - including chin and mandible</td>
</tr>
<tr>
<td>144</td>
<td>Mouth - including lips, tongue, throat and taste</td>
</tr>
<tr>
<td>145</td>
<td>Teeth</td>
</tr>
<tr>
<td>146</td>
<td>Nose - including nasal passages, sinus and smell</td>
</tr>
<tr>
<td>148</td>
<td>Face - multiple parts any combination of above parts</td>
</tr>
<tr>
<td>149</td>
<td>Face - forehead, cheeks, eyelids</td>
</tr>
<tr>
<td>150</td>
<td>Scalp</td>
</tr>
<tr>
<td>160</td>
<td>Skull</td>
</tr>
<tr>
<td>198</td>
<td>Head - multiple injury any combination of above parts</td>
</tr>
<tr>
<td>200</td>
<td>Neck</td>
</tr>
<tr>
<td>300</td>
<td>Upper extremities - not specified</td>
</tr>
<tr>
<td>310</td>
<td>Arm - above wrist not specified</td>
</tr>
<tr>
<td>311</td>
<td>Arm - upper arm humerus</td>
</tr>
<tr>
<td>313</td>
<td>Arm - elbow head of radius</td>
</tr>
<tr>
<td>315</td>
<td>Arm - forearm radius and ulna</td>
</tr>
<tr>
<td>318</td>
<td>Arm - multiple parts any combination of above parts</td>
</tr>
<tr>
<td>319</td>
<td>Arm - not specified</td>
</tr>
<tr>
<td>320</td>
<td>Wrist</td>
</tr>
<tr>
<td>330</td>
<td>Hand - not wrist or fingers</td>
</tr>
<tr>
<td>340</td>
<td>Fingers</td>
</tr>
<tr>
<td>398</td>
<td>Upper extremities - multiple parts any combination of above parts</td>
</tr>
<tr>
<td>400</td>
<td>Trunk - not specified</td>
</tr>
<tr>
<td>410</td>
<td>Abdomen - including internal organs and groin</td>
</tr>
<tr>
<td>411</td>
<td>Hernia</td>
</tr>
<tr>
<td>420</td>
<td>Back - including back muscles, spine and spinal cord</td>
</tr>
<tr>
<td>430</td>
<td>Chest - including ribs, breast bone and internal organs of the chest</td>
</tr>
<tr>
<td>440</td>
<td>Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks</td>
</tr>
<tr>
<td>450</td>
<td>Shoulders - scapula and clavicle</td>
</tr>
<tr>
<td>498</td>
<td>Trunk - use for side; multiple parts any combination of above parts</td>
</tr>
<tr>
<td>500</td>
<td>Lower extremities - not specified</td>
</tr>
<tr>
<td>510</td>
<td>Legs - above ankles, not specified</td>
</tr>
<tr>
<td>511</td>
<td>Thigh femur</td>
</tr>
<tr>
<td>513</td>
<td>Knee Patella</td>
</tr>
<tr>
<td>515</td>
<td>Lower leg tibia and fibula</td>
</tr>
<tr>
<td>518</td>
<td>Leg - multiple parts any combination of above parts</td>
</tr>
<tr>
<td>519</td>
<td>Leg - not specified</td>
</tr>
<tr>
<td>520</td>
<td>Ankle malleolus</td>
</tr>
<tr>
<td>530</td>
<td>Foot not ankle or toe</td>
</tr>
<tr>
<td>540</td>
<td>Toes</td>
</tr>
<tr>
<td>598</td>
<td>Lower extremities - multiple parts any combination of above parts</td>
</tr>
<tr>
<td>700</td>
<td>Multiple parts more than five major parts use only in fifth position of listing of body parts</td>
</tr>
<tr>
<td>800</td>
<td>Body system - not specific</td>
</tr>
<tr>
<td>801</td>
<td>Circulatory system - heart - other than heart attack, blood, arteries, veins, etc.</td>
</tr>
<tr>
<td>802</td>
<td>Circulatory system - Heart attack</td>
</tr>
<tr>
<td>810</td>
<td>Digestive system - stomach</td>
</tr>
<tr>
<td>820</td>
<td>Excretory system - kidneys, bladder, intestines, etc.</td>
</tr>
<tr>
<td>830</td>
<td>Musculo-skeletal system - bones, joints, tendons, muscles, etc.</td>
</tr>
<tr>
<td>840</td>
<td>Nervous system - not specified</td>
</tr>
<tr>
<td>841</td>
<td>Nervous system - stress</td>
</tr>
<tr>
<td>842</td>
<td>Nervous system - Psychiatric/psychological</td>
</tr>
<tr>
<td>850</td>
<td>Respiratory system - lungs, trachea, etc.</td>
</tr>
<tr>
<td>860</td>
<td>Skin dermatitis, etc.</td>
</tr>
<tr>
<td>870</td>
<td>Reproductive systems</td>
</tr>
<tr>
<td>880</td>
<td>Other body systems</td>
</tr>
<tr>
<td>999</td>
<td>Unclassified - insufficient information to identify body parts</td>
</tr>
</tbody>
</table>

---

Use this document to complete forms, but do not file this document with your forms.
DOCUMENT SEPARATOR SHEET

Product Delivery Unit: ADJ
Document Type: LEGAL DOCS
Document Title: APPLICATION FOR ADJUDICATION
Document Date: 04/16/2008
Author: UNIFORM ASSIGNED NAME

DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET
MM/DD/YYYY

IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OFFICE OR LAW FIRM, USE YOUR OFFICE’S UNIFORM ASSIGNED NAME. FOR ALL OTHERS ENTER YOUR NAME.

Office Use Only

Received Date: MM/DD/YYYY

DWC-CA form 10232.2 Rev. 11/2008 Page 1
STATE OF CALIFORNIA
DIVISION OF WORKERS’ COMPENSATION
WORKERS’ COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

Case No. [SBN (Numbers Only)]

SEE PAGE 6 FOR ADDITIONAL INSTRUCTIONS ON COMPLETING THIS FORM.

Venue choice is based upon (Completion of this section is required)

☑ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
☐ County of principal place of business of employee’s attorney (Labor Code section 5501.5(a)(3) or (d).)

VNO 3 DIGIT OFFICE CODE MUST BE IN COUNTY OF BOX CHECKED ABOVE

Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Injured Worker (Completion of this section is required)

JOHN
First Name
MI
Last Name
MILLER
Street Address/PO Box (Please leave blank spaces between numbers, names or words)
1234 WILLOW ROAD
International Address (Please leave blank spaces between numbers, names or words)

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

Name (Please leave blank spaces between numbers, names or words)

USE THE UNIFORM ASSIGNED NAME AND ADDRESS FOR THE CLAIMS ADMINISTRATOR, IF YOU ARE AN INSURANCE CARRIER. USE YOUR NAME AND ADDRESS, IF YOU ARE AN EMPLOYER OR A LIEN CLAIMANT.

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

DWC/WCAB Form 1A (11/2008) - (Page 1)
Employer Information (Completion of this section is required)

MUST CHECK ONE BOX

- Insured
- Self-Insured
- Legally Uninsured
- Uninsured

COMPANY INJURED EMPLOYEE WORKED FOR AT TIME OF INJURY:

Employer Name (Please leave blank spaces between numbers, names or words)

COMPANY ADDRESS - MUST INCLUDE STREET ADDRESS OR PO BOX NUMBER

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

MUST INCLUDE CITY, STATE AND ZIP CODE

City

State

Zip Code

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

NAME OF EMPLOYER’S INSURANCE CARRIER

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

INSURANCE CARRIER’S ADDRESS - MUST INCLUDE STREET ADDRESS OR PO BOX NUMBER

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

MUST INCLUDE CITY, STATE AND ZIP CODE

City

State

Zip Code

Claims Administrator Information (If known and if applicable)

UNIFORM ASSIGNED NAME OF CLAIMS ADMINISTRATOR

Name (Please leave blank spaces between numbers, names or words)

CLAIMS ADMINISTRATOR ADDRESS - MUST USE THE ONE IN UAN DATABASE

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

MUST INCLUDE CITY, STATE AND ZIP CODE

City

State

Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born

   (DATE OF BIRTH: MM/DD/YYYY)

   , while employed as a(n)

   (OCCUPATION AT THE TIME OF INJURY)

   (Choose only one)

   - specific injury

   - cumulative injury which began on

   (Start Date: MM/DD/YYYY)

   and ended on

   (End Date: MM/DD/YYYY)

   suffered a :

   - cumulative injury

   - specific injury

The injury occurred at

MAY PUT "INJURED ON JOB SITE" OR COMPLETE ADDRESS WHERE INJURY OCCURRED.

MUST INCLUDE CITY AND ZIPCODE.

USE "CA" FOR STATE.

City

State

Zip Code

Example

DWC/WCAB Form 1A (11/2008) - (Page 2)

WCAB1
Body Part 1: 420 BACK
Body Part 2: 100 HEAD
Body Part 3:
Body Part 4:
Other Body Parts:

2. The injury occurred as follows:
(Explain what the worker was doing at the time of injury and how the injury occurred)

3. Actual earnings at the time of injury:
   Rate of Pay $ ___
   Number of hours worked per week ___

4. The injury caused disability as follows:
   Last day off work due to injury: ___ MM/DD/YYYY
   First Period of Disability:
      Start Date ___ MM/DD/YYYY
      End Date ___ MM/DD/YYYY
   Second Period of Disability:
      Start Date ___ MM/DD/YYYY
      End Date ___ MM/DD/YYYY

5. Compensation:
   Compensation was paid: Yes No
   Total paid: _______________________
   Weekly rate(s): _______________________
   Date of last payment: ___ MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury? Yes No
7. Medical treatment:
Medical treatment was received: ☐ Yes ☐ No

All treatment was furnished by the Employer or Insurance Carrier: ☐ Yes ☐ No

Date of last treatment: __________________ MM/DD/YYYY

Other treatment was provided/paid by: ____________________________ (NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim? ☐ Yes ☐ No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

Case Number 1 _____________________________ Case Number 3 _____________________________

Case Number 2 _____________________________ Case Number 4 _____________________________

9. This application is filed because of a disagreement regarding liability for: MUST SELECT AT LEAST ONE.

☐ Temporary disability indemnity 
☐ Reimbursement for medical expense
☐ Medical treatment
☐ Compensation at proper rate
☐ Permanent disability indemnity
☐ Rehabilitation
☐ Supplemental Job Displacement/Return to Work
☐ Other (Specify) _____________________________
Is the Applicant Represented?  ☑ Yes  ☐ No  If "No", applicant is to sign and date below.

If "Yes", applicant’s representative is to complete the following and is to sign and date below.

☐ Law Firm/Attorney  ☐ Non-Attorney Representative

UNIFORM ASSIGNED NAME OF ATTORNEY FOR CLAIMS ADMINISTRATOR, INJURED WORKER OR LIEN CLAIMANT

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name

Attorney/Representative Last Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

MUST INCLUDE SIGNATURE WHEN APPLICANT IS REPRESENTED

APPLICANT MUST SIGN WHEN NOT REPRESENTED

Applicant Attorney/Representative Signature

Applicant Signature

Dated at _______________________, California

Date 04/16/2008

DOCUMENT DATE ON DOCUMENT SEPARATOR SHEET
INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS IS A PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendant(s) named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney's fee will be set by the Workers' Compensation Appeals Board at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

For “amended” applications, the venue choice must be the same as that specified on the original application, unless an order changing venue has issued. A street or P.O. Box address within the United States must be entered for the place where the injury occurred. Therefore, if the injury did not occur at a fixed or identifiable location (such as a field, a highway, or on water), or if the injury occurred outside of the United States, the employer's business address or another appropriate address must be specified; however, a short explanation regarding the place of injury may be appended to the application. If medical treatment has been paid for by Medi-Cal, Medicare, group health insurance, or a private carrier, please specify.

Service of Documents

Your attorney or agent will serve all documents in accordance with Labor Code section 5501 and the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file a Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the district office of the Workers' Compensation Appeals Board, or by calling the district office and requesting this form.
Example
Pursuant to the requirements set forth in Labor Code §4906(g), I declare as follows:

I have not violated Labor Code §139.3.

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.

A photostatic copy of this declaration shall be as valid as the original.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

DATED: 4/16/08

DATED: __________

APPLICANT'S ATTORNEY
State of California  
Department of Industrial Relations  
Division of Workers' Compensation

FEE DISCLOSURE STATEMENT

If you choose to be represented by an attorney, your attorney's fees will be deducted from your benefits. The fee will be approved by the Workers' Compensation Appeals Board, with consideration given to the: (1) responsibility assumed by the attorney; (2) care exercised in representing you; (3) time involved; and, (4) results obtained.

Attorney's fees normally range from 9% to 12% of the benefits awarded. However a fee of 15% may be charged if the case is complicated and time consuming. If your attorney has also represented you before the Rehabilitation Unit, there may also be a fee allowed for this representation.

There are certain circumstances where your employer (or his/her insurer) may be liable to pay your attorneys' fees. For example, if employer disputes a permanent disability evaluation obtained when you were not represented by an attorney, your employer may, be liable for any attorney fees you incur because of the dispute.

If at anytime you no longer wish to be represented by the attorney, you may withdraw from representation by notifying the attorney. If you withdraw from representation, the fee amount found by a workers' compensation judge to be the fair value of any work the attorney did in your case will be deducted from your award.

An Information and Assistance Officer may be able to answer your questions concerning your workers' compensation benefits at no charge to you. He/She may be able to resolve your problems without the need for litigation.

Call this toll-free number: 1-800-736-7401

Employee's Signature  
Date: 9/16/08

Employee's Name

Attorney's Signature  
Date: 

Attorney's Name

Address

Phone No.

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 felony.
<table>
<thead>
<tr>
<th>Product Delivery Unit</th>
<th>ADJ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Type</td>
<td>LEGAL DOCS</td>
</tr>
<tr>
<td>Document Title</td>
<td>VENUE VERIFICATION</td>
</tr>
<tr>
<td>Document Date</td>
<td>04/16/2008</td>
</tr>
<tr>
<td>Author</td>
<td>JOHN SMITH</td>
</tr>
</tbody>
</table>

**Document Title:** VENUE VERIFICATION

**Document Date:** 04/16/2008

**Author:** JOHN SMITH
VENUE AUTHORIZATION

I HEREBY AUTHORIZE MY WORKERS' COMPENSATION CASE(S) FOR INJURY(IES) DATED ________________ TO BE FILED AT THE ____________________________ WORKERS' COMPENSATION APPEALS BOARD.

DATED: ________________  APPLICANT

Applicant's Attorney:
[Redacted]

Drive, Suite

CA

TEL: (____)_______

FAX: (____)_______
Proof of Service

I am at least 18 years of age, not a party to this action, and I am a resident of or employed in the county where the mailing took place.

My business address is: [redacted]

On 04/16/2008 served a true copy of the following documents, along with supporting documents, described as: Application of adjudication of claim, 4906(g), fee disclosure statement and venue authorization by enclosing them in a sealed envelope addressed to each of the parties named and at the addresses set forth in the Party List, and placing each envelope for collection and mailing at the business address herein following our ordinary business practices, with postage fully prepaid, or by other previously agreed-upon method of electronic service.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: 04/16/2008

Declarant Signature [redacted]

Party List [redacted]