

## Cómo presentar una declaración de disposición para proceder

Presente una declaración de disposición para proceder (*declaration of readiness to proceed- DOR*) para solicitar una conferencia en su oficina local de la Junta de Apelaciones de Compensación de Trabajadores (*Workers' Compensation Appeals Board- WCAB*).

Se fijará una conferencia únicamente si usted presentó una solicitud para adjudicación del reclamo y se le ha asignado un número de caso en la *WCAB*. Si usted no tiene un número de caso en la *WCAB*, también necesitará presentar una solicitud para adjudicación del reclamo, lo que abre un caso para usted en la *WCAB* (consulte la guía 4 de *I&A*).

Llene el formulario siguiendo el ejemplo adjunto. Proporcione la información específica solicitada sobre cómo usted intentó resolver los problemas. Este formulario también se puede completar en

[http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCCAFORM10250\\_1.pdf](http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCCAFORM10250_1.pdf)

Cuando usted presenta la *DOR*, también debe presentar todos los informes médicos y documentos relevantes, y todas las cartas de la compañía de seguros acerca de los problemas en disputa.

Envíe el original a su oficina local de la *WCAB* y copias a todas las partes.

Presente los siguientes documentos con su formulario en el orden indicado:

- ✓ [Hoja de Portada de Documento](#)
- ✓ [Hoja de Separador de Documento](#) (para la Declaración de Disposición para Proceder)
- ✓ [Declaration of Readiness to Proceed](#) (Declaración de Disposición para Proceder)
- ✓ [Hoja de Separador de Documento](#) (para la Prueba de Entrega por Correo)
- ✓ [Proof of Service by Mail](#) (Prueba de Entrega por Correo)

Guarde copias de sus documentos presentados para su registro.

La *WCAB* revisará la *DOR*. Todas las partes serán notificadas por correo cuando se fije una conferencia.

Todos los documentos presentados en la *WCAB* deben incluir una hoja de portada de documento y una hoja de separador de documento. Por favor consulte las guías 17 y 18 de *I&A* para aprender cómo llenar estos formularios. Además todos los formularios deben ser escritos a máquina o a mano utilizando letra de molde para asegurar la legibilidad. Instrucciones de formularios adicionales pueden encontrarse en el manual de formularios *OCR* de *EAMS* en

[http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS\\_OCR%20handbook.pdf](http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf).

## Guía 5 de la Unidad de Información y Asistencia

Si necesita ayuda, llame a una [oficina de Información y Asistencia \(I&A\)](#) o asista a un [taller para trabajadores lesionados](#). Los números de teléfono de las oficinas locales de I&A están adjuntos a esta guía. Usted puede obtener información sobre un taller local de la oficina de I&A o en la Web en [www.dwc.ca.gov](http://www.dwc.ca.gov).

Si no tiene el nombre y la dirección de su compañía de seguros para completar un formulario, por favor enlace a <http://www.dir.ca.gov/DWC/EAMS/EAMS-LC/EAMSClaimsAdmins.asp>.

La información contenida en esta guía es de índole general y no pretende substituir asesoramiento legal. Los cambios en la ley o los datos específicos de su caso podrían resultar en interpretaciones legales distintas de las que aquí se presentan.

Al enviar documentos a una oficina regional, por favor asegúrese que no estén doblados ni engrapados. Envíelos en un sobre grande de manila. Por favor consulte con el manual de formularios *OCR* de *EAMS* para instrucciones adicionales.

# WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

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**ANAHEIM, 92806-2131**

1065 N PacificCenter Drive, Suite 170  
Information & Assistance Unit (714) 414-1800

**BAKERSFIELD, 93301-1929**

1800 30<sup>th</sup> Street, Suite 100  
Information & Assistance Unit (661) 395-2514

**EUREKA, 95501-0481 \* Satellite office \***

100 "H" Street, Suite 202  
Information & Assistance Unit (707) 441-5723

**FRESNO, 93721-2219**

2550 Mariposa Street, Suite 4078  
Information & Assistance Unit (559) 445-5355

**LONG BEACH, 90802-4339**

300 OceanGate Street, Suite 200  
Information & Assistance Unit (562) 590-5240

**LOS ANGELES, 90013-1105**

320 W 4<sup>th</sup> Street, 9<sup>th</sup> Floor  
Information & Assistance Unit (213) 576-7389

**MARINA DEL REY, 90292-6902**

4720 Lincoln Boulevard, 2<sup>nd</sup> and 3<sup>rd</sup> floors  
Information & Assistance Unit (310) 482-3858

**OAKLAND, 94612-1499**

1515 Clay Street, 6<sup>th</sup> Floor  
Information & Assistance Unit (510) 622-2861

**OXNARD, 93030-7912**

1901 N Rice Avenue, Suite 100  
Information & Assistance Unit (805) 485-3528

**POMONA, 91768-1653**

732 Corporate Center Drive  
Information & Assistance Unit (909) 623-8568

**REDDING, 96002-0940**

250 Hemsted Drive, 2<sup>nd</sup> Fl, Ste. B  
Information & Assistance Unit (530) 225-2047

**RIVERSIDE, 92501-3337**

3737 Main Street, Suite 300  
Information & Assistance Unit (951) 782-4347

**SACRAMENTO, 95834-2962**

160 Promenade Circle, Suite 300  
Information & Assistance Unit (916) 928-3158

**SALINAS, 93906-2204**

1880 N Main Street, Suites 100 & 200  
Information & Assistance (831) 443-3058

**SAN BERNARDINO, 92401-1411**

464 W Fourth Street, Suite 239  
Information & Assistance Unit (909) 383-4522

**SAN DIEGO, 92108-4424**

7575 Metropolitan Drive, Suite 202  
Information & Assistance Unit (619) 767-2082

**SAN FRANCISCO, 94102-7014**

455 Golden Gate Avenue, 2<sup>nd</sup> Floor  
Information & Assistance Unit (415) 703-5020

**SAN JOSE, 95113-1402**

100 Paseo de San Antonio, Suite 241  
Information & Assistance Unit (408) 277-1292

**SAN LUIS OBISPO, 93401-8736**

4740 Allene Way, Suite 100  
Information & Assistance Unit (805) 596-4159

**SANTA ANA, 92701-4070**

605 W Santa Ana Boulevard, Bldg 28, Suite 451  
Information & Assistance Unit (714) 558-4597

**SANTA BARBARA, 93101-7538 \* Satellite office \***

130 E Ortega St.  
Information & Assistance Unit (805) 568-1390

**SANTA ROSA, 95404-4771**

50 "D" Street, Suite 420  
Information & Assistance Unit (707) 576-2452

**STOCKTON, 95202-2314**

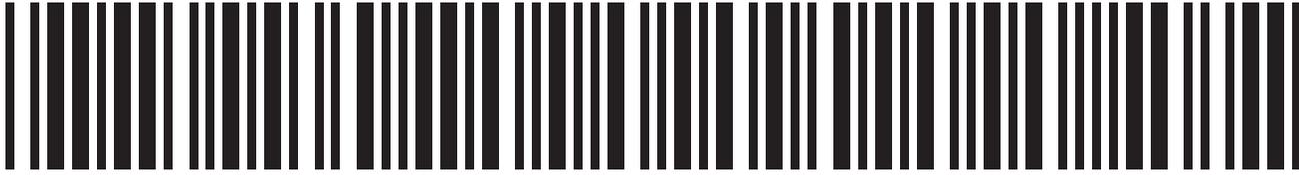
31 E Channel Street, Suite 344  
Information & Assistance Unit (209) 948-7980

**VAN NUYS, 91401-3370**

6150 Van Nuys Boulevard, Suite 105  
Information & Assistance Unit (818) 901-5374

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

Date:(MM/DD/YYYY)

SSN: \_\_\_\_\_

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 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

**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: \_\_\_\_\_

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 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

Specific Injury

Case 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)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_



Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

Specific Injury

Case Number 5

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: \_\_\_\_\_



Specific Injury

Case Number 6

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: \_\_\_\_\_

Specific Injury

Case Number 7

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: \_\_\_\_\_

Specific Injury

Case Number 8

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: \_\_\_\_\_



Specific Injury

Case Number 9

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: \_\_\_\_\_

Specific Injury

Case Number 10

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: \_\_\_\_\_

Specific Injury

Case Number 11

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: \_\_\_\_\_



Specific Injury

Case Number 12

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: \_\_\_\_\_

Specific Injury

Case Number 13

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: \_\_\_\_\_

Specific Injury

Case Number 14

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: \_\_\_\_\_



Specific Injury

Case Number 15

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: \_\_\_\_\_



Specific Injury

Case Number 16

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: \_\_\_\_\_



## District office codes for place of venue

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

**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.

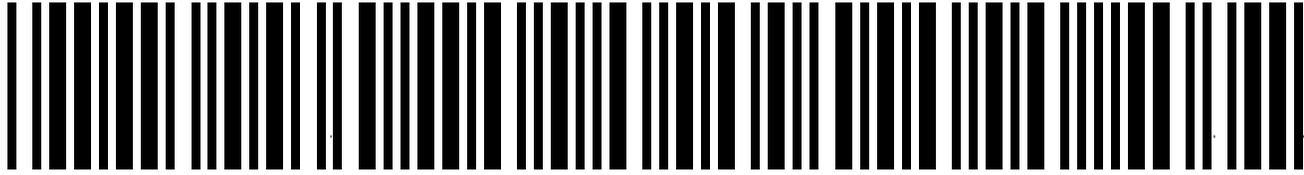
100	Head - not specified	500	Lower extremities - not specified
110	Brain	510	Legs - above ankles, not specified
120	Ear - not specified	511	Thigh femur
121	Ear - external	513	Knee Patella
124	Ear - internal including hearing	515	Lower leg tibia and fibula
130	Eye - including optic nerves and vision	518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

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

STATE OF CALIFORNIA  
DWC DISTRICT OFFICE

EJEMPLO

DOCUMENT COVER SHEET



Is this a new case? Yes  No  Companion Cases Exist  Walkthrough Yes  No

More than 15 Companion Cases

**FECHA DE HOY**

Date:(MM/DD/YYYY)

SSN:

**SU NÚMERO DE SEGURO SOCIAL**

Specific Injury

Cumulative Injury

**NÚMERO DE CASO EAMS**

Case Number 1

**FECHA DE LA LESIÓN**

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

**SI ES UN CASO NUEVO DEJE EN BLANCO**

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

**UTILICE UN CÓDIGO DE LAS LISTA DE CÓDIGOS DE LAS PARTES DEL CUERPO, CONSULTE LA P.8**

Other Body Parts: \_\_\_\_\_

**Please check unit to be filed on ( check only one box ) MARQUE LA CASILLA DE LA UNIDAD APROPIADA**

ADJ  DEU  SIF  UEF  INT  RSU

**Companion Cases CASOS COMPAÑEROS**

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: \_\_\_\_\_

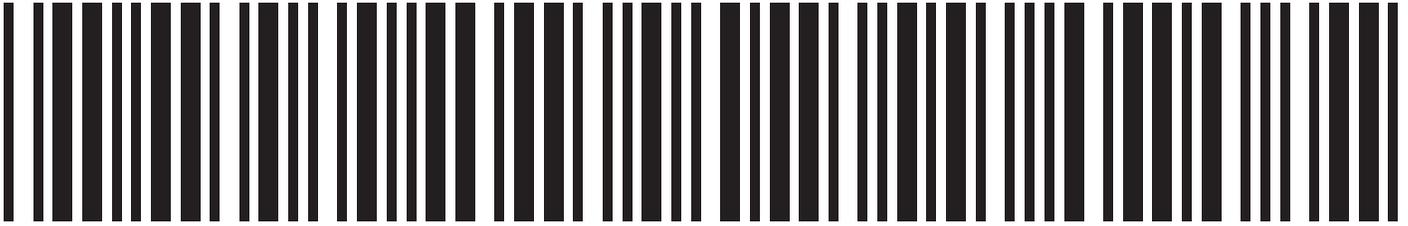
Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

\_\_\_\_\_

Document Type

\_\_\_\_\_

Document Title

\_\_\_\_\_

Document Date

\_\_\_\_\_

MM/DD/YYYY

Author

\_\_\_\_\_

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## Office Use Only

Received Date

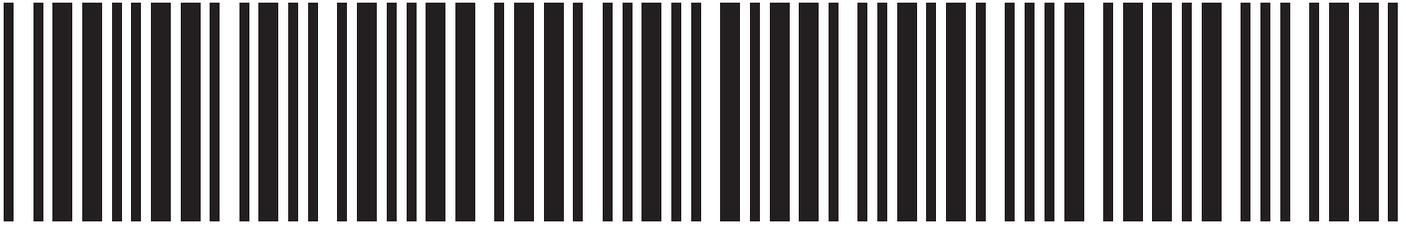
\_\_\_\_\_

MM/DD/YYYY



# DOCUMENT SEPARATOR SHEET

**EJEMPLO**



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

DECLARATION OF READINESS TO PROCEED

Document Date

FECHA EN QUE LLENÓ EL FORMULARIO

MM/DD/YYYY

Author

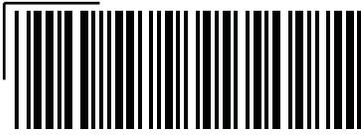
SU NOMBRE

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## Office Use Only

Received Date

MM/DD/YYYY



**STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
DECLARATION OF READINESS TO PROCEED**



NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration.

Case No. \_\_\_\_\_

**Applicant**

First Name \_\_\_\_\_

MI

Last Name \_\_\_\_\_

**VS**

**Employer Information**

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 \_\_\_\_\_

Declarants: Please designate your role (Please Select Only One)

- Employee       Applicant       Defendant       Lien Claimant

Declarant requests: (Please Select Only One)

- Mandatory Settlement Conference       Status Conference       Rating MSC\*       Priority Conference  
 Lien Conference

At the present time the principal issues are: (Check all that apply)

- Compensation Rate       Rehabilitation/SJDB       Temporary Disability       Self-Procured Medical Treatment  
 Permanent Disability       Future Medical Treatment       AOE/COE       Discovery  
 Employment       Other \_\_\_\_\_

Declarant relies on the report(s) of:

Doctors (s) \_\_\_\_\_ date \_\_\_\_\_

MM/DD/YYYY

\*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

Declarant states under penalty perjury that he or she is presently ready to proceed to hearing on the issues below and has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed below:

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and that all medical reports in my possession or control have been filed and served as required by the rules promulgated by the Court Administrator.

Copies of this Declaration have been served this date as shown on the attached proof of service.

Declarant's Signature \_\_\_\_\_

\_\_\_\_\_  
Name of declarant or name of the law firm of the declarant (Print or Type)

\_\_\_\_\_  
Address (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
Phone Number

Date \_\_\_\_\_  
MM/DD/YYYY

## INSTRUCTIONS

1. This Declaration must be completed and filed before any case will be set for hearing at the request of any party. A party may request a mandatory settlement conference hearing, status conference hearing, rating mandatory settlement conference hearing, priority conference hearing or a lien conference.

**A mandatory settlement conference** is held to assist the parties in resolving the dispute. If the dispute cannot be resolved at that time, the parties should be ready to frame issues, record stipulations, list exhibits, and list the witnesses who will testify at trial. A trial is set only at the discretion of the judge and is set for the purpose of receiving evidence.

**A rating mandatory settlement conference** is a mandatory settlement conference but ratings of the medical reports will be available at the time of the conference.

A status conference is not a mandatory settlement conference but a proceeding for which judicial attention is required. It can include, but is not limited to, a conference in a complicated case in which discovery is not complete and the parties need the judge's guidance.

**A priority conference** is a conference held under Labor Code section 5502(c) in which the injured worker is represented **by an attorney and the issues include employment and/or injury arising out of and in the course of employment.**

**A lien conference** is a proceeding for which judicial attention is required to resolve disputes on liens. If the dispute cannot be resolved at that time, the parties should be ready to frame issues, record stipulations, list exhibits, and list the witnesses who will testify at trial.

2. A lien claimant may file a declaration of readiness to proceed only after the underlying case has been resolved or where the applicant chooses not to proceed with his or her case. (Labor Code § 4903.6 (b).) A declaration of readiness filed by a lien claimant shall be accompanied by the verification required by section 10770.6 of title 8 of the California Code of Regulation. The failure to attach the verification or an incorrect verification may be a basis for sanctions.

3. Unless notified otherwise, no witness other than the applicant need attend conference hearings. **Claims adjusters and lien claimants must be present or available by telephone.**

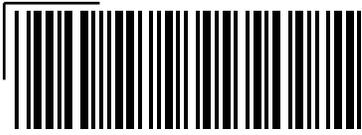
4. The party requiring an interpreter must arrange for the presence of an interpreter, except that the defendant(s) must arrange for the presence of the interpreter if the injured worker is not represented by an attorney.

5. Continuances are not favored and none will be granted after the filing of this Declaration without a clear and timely showing of good cause.

6. The Workers' Compensation Appeals Board favors the presentation of medical evidence in the form of written reports.

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Workers' Compensation Information and Assistance - 1 (800) 736-7401



**STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
DECLARATION OF READINESS TO PROCEED**

**EJEMPLO**

NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration.

**NÚMERO DE CASO DE EAMS**

Case No. \_\_\_\_\_

**Applicant**

**SU PRIMER NOMBRE**

First Name \_\_\_\_\_ MI \_\_\_\_\_

**SU APELLIDO**

Last Name \_\_\_\_\_ **VS**

**Employer Information**

**NOMBRE DEL EMPLEADOR CON QUIÉN USTED TRABAJABA AL TIEMPO DE LA LESIÓN**

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

**DIRECCIÓN DEL EMPLEADOR**

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

**CIUDAD DEL EMPLEADOR**

City \_\_\_\_\_

**ESTADO**

State \_\_\_\_\_

**CÓDIGO POSTAL**

Zip Code \_\_\_\_\_

Declarants: Please designate your role (Please Select Only One)

- Employee     Applicant     Defendant     Lien Claimant

Declarant requests: (Please Select Only One)

**SELECCIONE LA CLASE DE AUDIENCIA QUE QUIERE (VEA LA PÁGINA 3 DE LA HOJA DE INSTRUCCIÓN PARA LAS DEFINICIONES)**

- Mandatory Settlement Conference     Status Conference     Rating MSC\*     Priority Conference  
 Lien Conference

At the present time the principal issues are: (Check all that apply)

**MARQUE TODAS LAS CUESTIONES QUE ACTUALMENTE APLICAN A ESTA SOLICITUD**

- Compensation Rate     Rehabilitation/SJDB     Temporary Disability     Self-Procured Medical Treatment  
 Permanent Disability     Future Medical Treatment     AOE/COE     Discovery  
 Employment     Other \_\_\_\_\_

Declarant relies on the report(s) of:

Doctors (s) **NOMBRE DEL MÉDICO CUYO INFORME ESTÁ USANDO** \_\_\_\_\_ date **FECHA DEL INFORME** \_\_\_\_\_

MM/DD/YYYY

\*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

Declarant states under penalty perjury that he or she is presently ready to proceed to hearing on the issues below and has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed below:

DECLARE LOS ESFUERZOS QUE HA HECHO PARA RESOLVER LA DISPUTA

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and that all medical reports in my possession or control have been filed and served as required by the rules promulgated by the Court Administrator.

Copies of this Declaration have been served this date as shown on the attached proof of service.

Declarant's Signature SU FIRMA

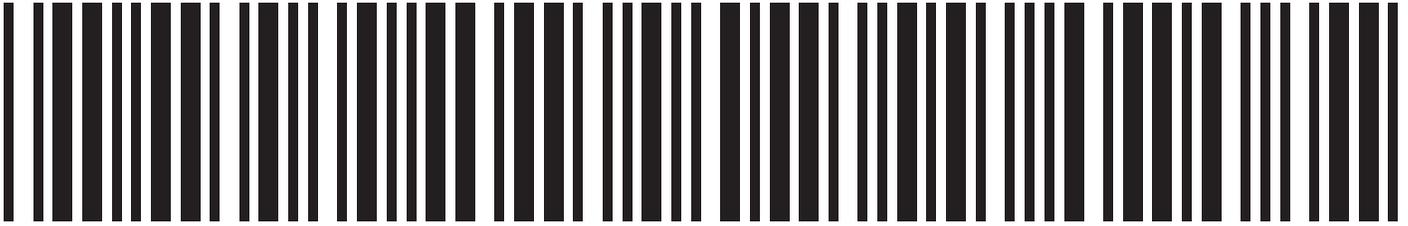
SI NO TIENE ABOGADO, ESCRIBA SU NOMBRE USANDO LETRAS DE MOLDE
Name of declarant or name of the law firm of the declarant (Print or Type)

SU DIRECCIÓN
Address (Please leave blank spaces between numbers, names or words)

SU NÚMERO DE TELÉFONO
Phone Number

Date FECHA DE HOY
MM/DD/YYYY

# DOCUMENT SEPARATOR SHEET



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\_\_\_\_\_

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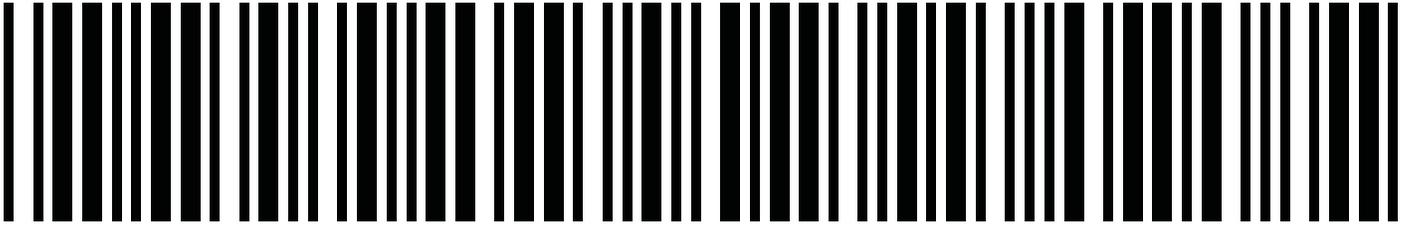
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Author

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Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of \_\_\_\_\_ California. I am over the age of eighteen years, my (business/residence) address is:

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On \_\_\_\_\_, I served the attached \_\_\_\_\_ on the \_\_\_\_\_ in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at

\_\_\_\_\_ addressed as follows \_\_\_\_\_

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) \_\_\_\_\_, at \_\_\_\_\_ California.

Type or print name \_\_\_\_\_

Signature \_\_\_\_\_

**EJEMPLO**

**Prueba de Entrega por Correo**

Yo declaro que:

Soy (residente de/empleado en) el condado de **SU CONDADO** California. Tengo

más de dieciocho años de edad y mi dirección de (negocio/residencia) es:

**SU DOMICILIO**

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El **FECHA DE HOY**, yo entregue el adjunto **EL NOMBRE DEL DOCUMENTO QUE ESTÁ ENVIANDO POR CORREO**

a **NOMBRE DE LAS PARTES A QUIENES LES ESTÁ ENVIANDO EL DOCUMENTO** en dicho caso,

poniendo una copia verdadera del mismo adjunto, en un sobre sellado con el franqueo

completamente pagado, en el correo de los Estados Unidos en **CIUDAD DESDE DONDE ESTÁ ENVIANDO EL DOCUMENTO**

con la siguiente dirección

**NOMBRE Y DIRECCIÓN DE LA PARTES A QUIENES LES ESTÁ ENVIANDO EL DOCUMENTO**

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Yo declaro bajo pena de perjurio bajo las leyes del Estado de California que lo siguiente es verdadero y correcto y que esta declaración fue ejecutada en

(fecha) **FECHA DE HOY** en **CIUDAD** California.

Escriba su nombre **ESCRIBA SU NOMBRE CON LETRA DE MOLDE**

Firma **SU FIRMA**

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