

## Information & Assistance Unit guide 4

### How to file an application for adjudication of claim

Complete this form if you have a disagreement with your employer or its insurance company about your case and you want it resolved by your local Workers' Compensation Appeals Board (WCAB). Filing this form opens a case with the WCAB.

You can also complete this form if you think you may need the WCAB to resolve a dispute in the future and the time allowed for you to file the application could run out. If you have questions about whether time limits apply in your case, contact your local Information and Assistance office. You can get information on contacting a local I&A office on the Web at [www.dwc.ca.gov](http://www.dwc.ca.gov).

Complete the form and follow the instructions attached. This form can also be completed at <http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWC1.pdf>.

Please note that a hearing in your case will not be scheduled until a declaration of readiness to proceed is filed (see I&A guide 5).

The following papers must be included with your completed application:

1. A copy of your claim for workers' compensation benefits (required only for injuries that happened between 1-1-90 and 12-31-93). See I&A guide 1.
2. Declaration required by law (Labor Code section 4906(h) -- see attached). A proof of service is recommended. See attached.

Send the original to your local WCAB office and copies to all the parties.

Submit the following documents with your form filing in the order shown:

- ✓ [Document Cover Sheet](#)
- ✓ [Document Separator Sheet](#) (*for Application for Adjudication of Claim*)
- ✓ [Application for Adjudication of Claim](#)
- ✓ [Document Separator Sheet](#) (*for Proof Of Service By Mail*)
- ✓ [Proof Of Service By Mail](#)
- ✓ [Document Separator Sheet](#) (*for Declaration Pursuant to Labor Code Section 4906(h)*)
- ✓ [Declaration Pursuant to Labor Code Section 4906\(h\)](#)

Keep copies of your filings for your records.

## Information & Assistance Unit guide 4

All documents filed with the WCAB must include a document cover sheet and document separator sheet. Please see I&A guides 17 and 18 to learn how to complete these forms. In addition all forms must be typed or handwritten in block letters to insure legibility. Additional form instructions can be found on the EAMS OCR handbook at [http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS\\_OCR%20handbook.pdf](http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf).

If you need help, call an [Information and Assistance \(I&A\) office](#), or attend a [workshop for injured workers](#). The local I&A phone numbers are attached to this guide. You can get information on a local workshop from the I&A office or on the Web at [www.dwc.ca.gov](http://www.dwc.ca.gov).

If you do not have the name and address of your claims administrator to complete a form, please link to <http://www.dir.ca.gov/DWC/EAMS/EAMS-LC/EAMSClaimsAdmins.asp>.

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations different than those present here.

When sending documents to a district office, please make sure they are not folded or stapled. Send them in a large manila envelope. Please see the EAMS OCR forms handbook for further instructions.

## **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 \***

409 "K" Street, Room 201  
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**

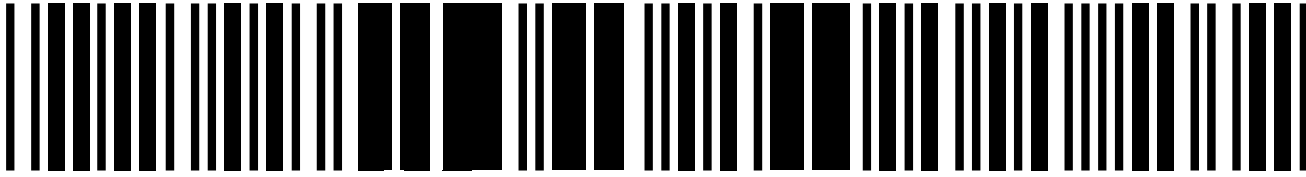
31 E Channel Street, Suite 344  
Information & Assistance Unit **(209) 948-7980**

**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  SAU  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)

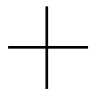
Body Part 1: \_\_\_\_\_

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
LAO	Los Angeles
LBO	Long Beach
MDR	Marina del Rey
OAK	Oakland
OXN	Oxnard
POM	Pomona
RDG	Redding
RIV	Riverside
SAC	Sacramento
SAL	Salinas
SBA	Santa Barbara**
SBR	San Bernardino
SDO	San Diego
SFO	San Francisco
SJO	San Jose
SLO	San Luis Obispo
SRO	Santa Rosa
STK	Stockton
VNO	Van Nuys

*\* Eureka is a satellite office of Santa Rosa district office. \*\* Santa Barbara is a satellite office of the Oxnard district office.*

**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		

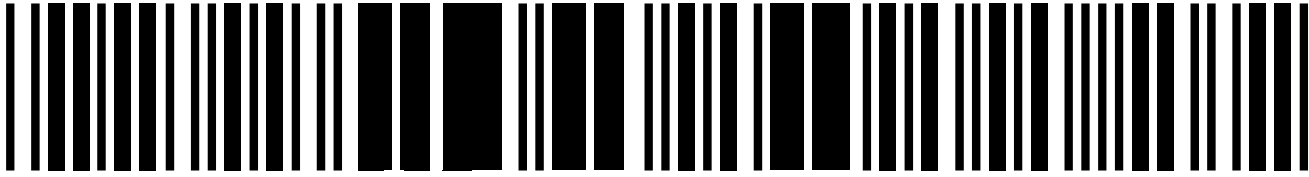
**Use this document to complete forms, but do not file this document with your forms.**



STATE OF CALIFORNIA  
DWC DISTRICT OFFICE

**SAMPLE**

DOCUMENT COVER SHEET



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

More than 15 Companion Cases

**TODAY'S DATE**

Date:(MM/DD/YYYY)

**YOUR SOCIAL SECURITY NUMBER**

SSN:

**EAMS CASE NUMBER**

Case Number 1

Specific Injury

**DATE OF 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 NEW CASE LEAVE BLANK**

**USE CODE FROM BODY PART CODE LIST, SEE PAGE 8**

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

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

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

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     SAU     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: \_\_\_\_\_

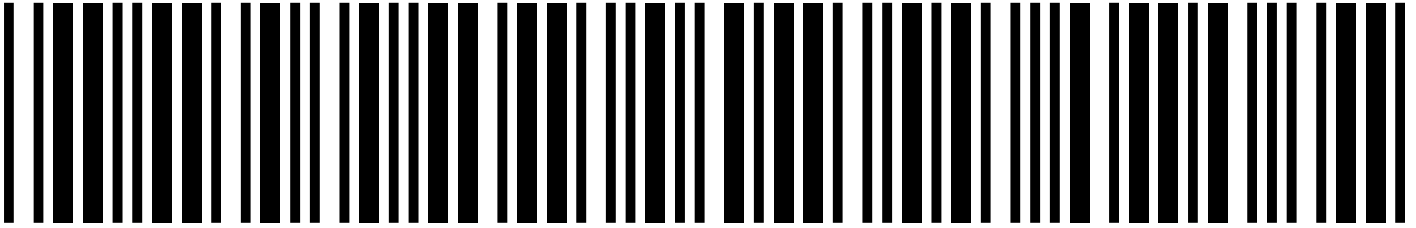
Body Part 2: \_\_\_\_\_

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

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



# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

\_\_\_\_\_

Document Type

\_\_\_\_\_

Document Title

\_\_\_\_\_

Document Date

\_\_\_\_\_

MM/DD/YYYY

Author

\_\_\_\_\_

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## Office Use Only

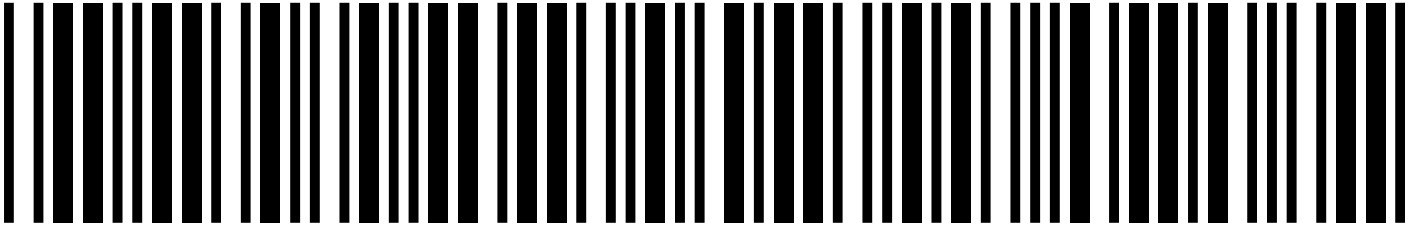
Received Date

\_\_\_\_\_

MM/DD/YYYY



# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

APPLICATION FOR ADJUDICATION

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

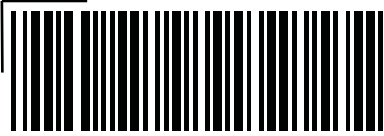
YOUR NAME

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**Office Use Only**

Received Date

MM/DD/YYYY



**STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
APPLICATION FOR ADJUDICATION OF CLAIM**



Amended Application

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

SSN (Numbers Only) \_\_\_\_\_

**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).)

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

**Injured Worker (Completion of this section is required)**

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

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

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words) \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Applicant (If other than Injured Worker)**

- Insurance Carrier
- Employer
- Lien Claimant

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

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Employer Information (Completion of this section is required)**

Insured

Self-Insured

Legally Uninsured

Uninsured



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

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

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

Insurance 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

**IT IS CLAIMED THAT (Complete all relevant information):**

1. The injured worker, born \_\_\_\_\_, while employed as a(n) \_\_\_\_\_  
(DATE OF BIRTH: MM/DD/YYYY) (OCCUPATION AT THE TIME OF INJURY)

**(Choose only one)**

specific injury \_\_\_\_\_  
(Date of injury: MM/DD/YYYY)

suffered a :

cumulative injury which began on \_\_\_\_\_ and ended on \_\_\_\_\_  
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

The injury occurred at \_\_\_\_\_

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

City

State

Zip Code





(State which parts of the body were injured)

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

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

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 OCCURED)

Empty rectangular box for injury description.

**3. Actual earnings at the time of injury:**

Rate of Pay \$ \_\_\_\_\_  Monthly  Weekly  Hourly  
State value of tips, meals, lodging, or other advantages, regularly received \$ \_\_\_\_\_  Monthly  Weekly  Hourly

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

Second Period of Disability: Start Date \_\_\_\_\_ End Date \_\_\_\_\_  
MM/DD/YYYY 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:**

- |  |   |
|--|---|
| <input type="checkbox"/> Temporary disability indemnity    | <input type="checkbox"/> Permanent disability indemnity               |
| <input type="checkbox"/> Reimbursement for medical expense | <input type="checkbox"/> Rehabilitation                               |
| <input type="checkbox"/> Medical treatment                 | <input type="checkbox"/> Supplemental Job Displacement/Return to Work |
| <input type="checkbox"/> Compensation at proper rate       | <input type="checkbox"/> 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

\_\_\_\_\_  
Law Firm or Company Name (If Applicable)

\_\_\_\_\_  
Law Firm Number (If Applicable)

\_\_\_\_\_  
Attorney/Representative First Name \_\_\_\_\_  
MI

\_\_\_\_\_  
Attorney/Representative Last Name

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

\_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Applicant Attorney/Representative Signature \_\_\_\_\_  
Applicant Signature

Dated at \_\_\_\_\_, California  
City

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

# 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.**

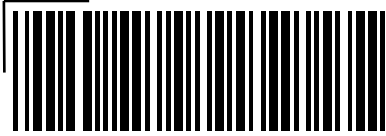
## **Service of Documents**

**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.**



**STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
APPLICATION FOR ADJUDICATION OF CLAIM**

**SAMPLE**

**LEAVE BLANK**

Amended Application

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

**YOUR SSN**

SSN (Numbers Only) \_\_\_\_\_

**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).)

← **SELECT ONE**

**USE 3 LETTER OFFICE CODE FROM DOCUMENT COVER SHEET**

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

**Injured Worker (Completion of this section is required)**

**YOUR FIRST NAME**

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

**YOUR LAST NAME**

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

**YOUR MAILING ADDRESS**

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words) \_\_\_\_\_

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

**YOUR CITY**

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Applicant (If other than Injured Worker)**

- Insurance Carrier
- Employer
- Lien Claimant

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

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Employer Information (Completion of this section is required)**

**SAMPLE**

Insured

Self-Insured

Legally Uninsured

Uninsured

**NAME OF COMPANY YOU WERE WORKING FOR AT TIME OF INJURY**

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

**COMPANY ADDRESS**

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

**COMPANY CITY**

City

State

Zip Code

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

**NAME OF COMPANY INSURANCE CARRIER**

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

**INSURANCE CARRIER ADDRESS**

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

**INSURANCE CARRIER CITY**

City

State

Zip Code

**Claims Administrator Information (If known and if applicable)**

**NAME OF CLAIMS ADMINISTRATOR**

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

**CLAIMS ADMINISTRATOR ADDRESS**

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

**CLAIMS ADMINISTRATOR CITY**

City

State

Zip Code

**IT IS CLAIMED THAT (Complete all relevant information):**

1. The injured worker, born **YOUR BIRTH DATE**, while employed as a(n) **YOUR JOB TITLE WHEN INJURED**  
(DATE OF BIRTH: MM/DD/YYYY) (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

specific injury

**DATE OF ACCIDENT**

(Date of injury: MM/DD/YYYY)

suffered a :

cumulative injury

which began on

(Start Date: MM/DD/YYYY)

and ended on

(End Date: MM/DD/YYYY)

The injury occurred at

**ADDRESS WHERE ACCIDENT TOOK PLACE**

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

City

State

Zip Code

(State which parts of the body were injured)

Body Part 1: PART OF BODY THAT WAS INJURED, USE LIST FROM DOCUMENT COVERSHEET

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

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 OCCURED)

INDICATE WHAT YOU WERE DOING AT THE TIME OF INJURY

3. Actual earnings at the time of injury:

Rate of Pay \$ \_\_\_\_\_  Monthly  Weekly  Hourly

State value of tips, meals, lodging, or other advantages, regularly received \$ \_\_\_\_\_  Monthly  Weekly  Hourly

Number of hours worked per week \_\_\_\_\_

4. The injury caused disability as follows:

Last day off work due to injury: LAST DAY WORKED  
MM/DD/YYYY

First Period of Disability: Start Date FIRST DAY OFF WORK End Date DATE RETURNED TO WORK  
MM/DD/YYYY MM/DD/YYYY

Second Period of Disability: Start Date \_\_\_\_\_ End Date \_\_\_\_\_  
MM/DD/YYYY MM/DD/YYYY

5. Compensation:

Compensation was paid:  Yes  No

Total paid: \_\_\_\_\_

Weekly rate(s): FROM CLAIMS ADMINISTRATOR

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

IF YOU OR PRIVATE INSURANCE PAID FOR MEDICAL TREATMENT

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:

LIST ANY OTHER CASES FILED WITH DWC

\_\_\_\_\_  
Case Number 1

\_\_\_\_\_  
Case Number 3

\_\_\_\_\_  
Case Number 2

\_\_\_\_\_  
Case Number 4

9. This application is filed because of a disagreement regarding liability for:

- |  |   |
|--|---|
| <input type="checkbox"/> Temporary disability indemnity    | <input type="checkbox"/> Permanent disability indemnity               |
| <input type="checkbox"/> Reimbursement for medical expense | <input type="checkbox"/> Rehabilitation                               |
| <input type="checkbox"/> Medical treatment                 | <input type="checkbox"/> Supplemental Job Displacement/Return to Work |
| <input type="checkbox"/> Compensation at proper rate       | <input type="checkbox"/> 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.

**SAMPLE**

Law Firm/Attorney  Non-Attorney Representative

\_\_\_\_\_  
Law Firm or Company Name (If Applicable)

\_\_\_\_\_  
Law Firm Number (If Applicable)

\_\_\_\_\_  
Attorney/Representative First Name \_\_\_\_\_  
MI

\_\_\_\_\_  
Attorney/Representative Last Name

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

\_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code

YOUR SIGNATURE

\_\_\_\_\_  
Applicant Attorney/Representative Signature

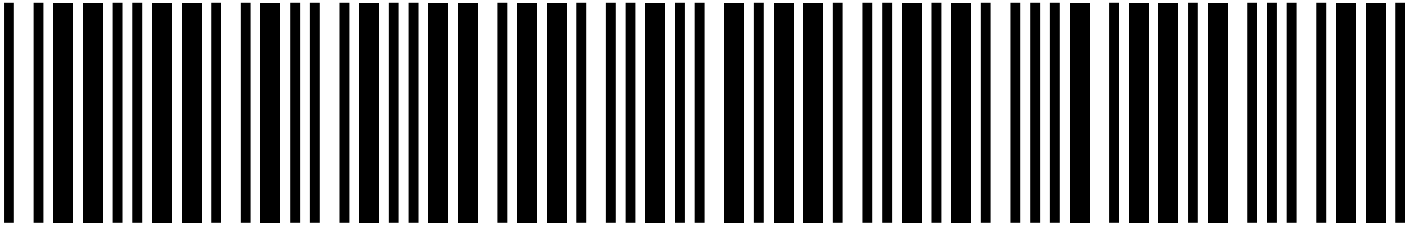
\_\_\_\_\_  
Applicant Signature

Dated at \_\_\_\_\_, California  
City

Date TODAY'S DATE  
\_\_\_\_\_  
MM/DD/YYYY



# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

\_\_\_\_\_

Document Type

\_\_\_\_\_

Document Title

\_\_\_\_\_

Document Date

\_\_\_\_\_

MM/DD/YYYY

Author

\_\_\_\_\_

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## Office Use Only

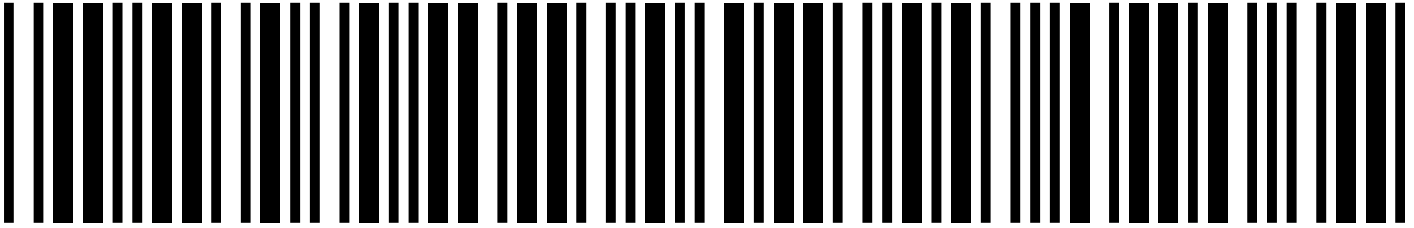
Received Date

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# 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



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:

On \_\_\_\_\_, I served the attached \_\_\_\_\_  
on the parties listed below 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:

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 \_\_\_\_\_

Proof of Service by Mail

I declare that:

I am (resident of / employed in) the county of YOUR COUNTY, California.

I am over the age of eighteen years, my (business / residence) address is:

PUT YOUR HOME ADDRESS HERE

On TODAY'S DATE, I served the attached NAME OF DOCUMENT

on the parties listed below 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

CITY WHERE YOU MAILED THIS addressed as follows:

1) WORKERS' COMPENSATION APPEALS BOARD: ADDRESS  
2) INSURANCE COMPANY: NAME, ADDRESS AND CLAIM NUMBER  
3) DEFENSE ATTORNEY (IF KNOWN): NAME AND ADDRESS  
4) ALL OTHER PARTIES INVOLVED IN YOUR CASE: NAME AND ADDRESS

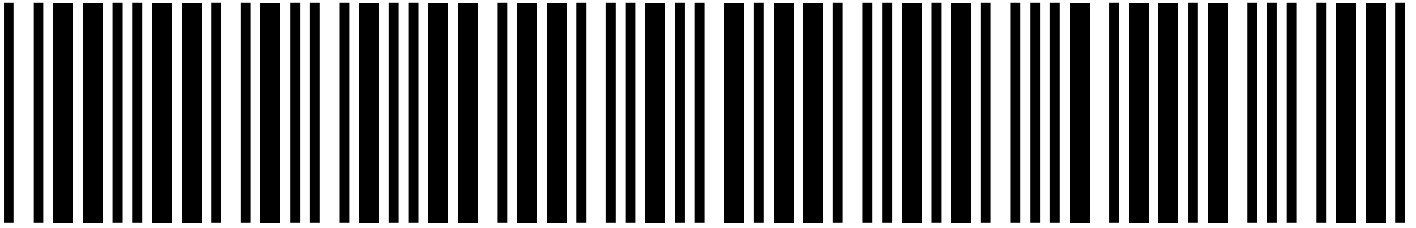
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) TODAY'S DATE, at CITY, California.

Type or print name PRINT YOUR NAME

Signature SIGN YOUR NAME

# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

\_\_\_\_\_

Document Type

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Document Title

\_\_\_\_\_

Document Date

\_\_\_\_\_

MM/DD/YYYY

Author

\_\_\_\_\_

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## Office Use Only

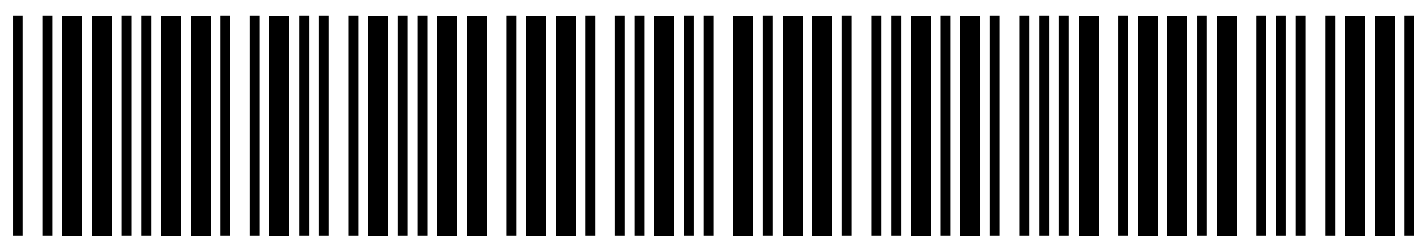
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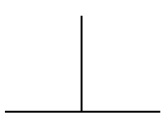
Document Date   
MM/DD/YYYY

Author

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**Office Use Only**

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



**DECLARATION PURSUANT TO LABOR CODE SECTION 4906(h)**

Pursuant to Labor Code Section 4906(h), I declare under penalty of perjury that I have not violated Section 139.3 and 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.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature

Before signing this form, you should be aware that: “Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers’ compensation benefits or payments is guilty of a felony.”



**DECLARATION PURSUANT TO LABOR CODE SECTION 4906(h)**

Pursuant to Labor Code Section 4906(h), I declare under penalty of perjury that I have not violated Section 139.3 and 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.

Date: TODAY'S DATE

YOUR SIGNATURE  
Signature

Before signing this form, you should be aware that: “Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers’ compensation benefits or payments is guilty of a felony.”