

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.

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.

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.

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

ANAHEIM, 92806-2131

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

BAKERSFIELD, 93301-1929

1800 30th 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 4th Street, 9th Floor
Information & Assistance Unit (213) 576-7389

MARINA DEL REY, 90292-6902

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

OAKLAND, 94612-1499

1515 Clay Street, 6th 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, 2nd 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, 2nd 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

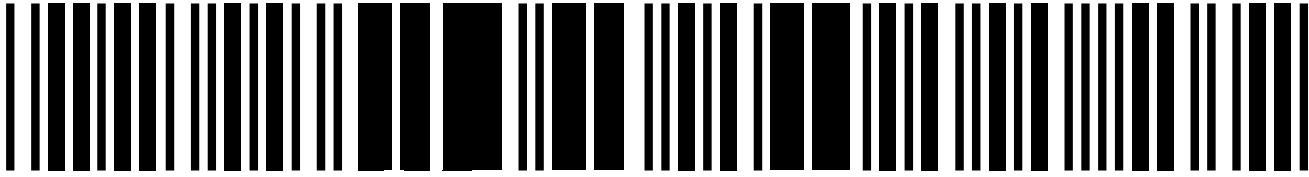
31 E Channel Street, Suite 344
Information & Assistance Unit (209) 948-7980

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)

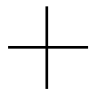
Body Part 1: _____

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>	
Abbreviation	Office
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		

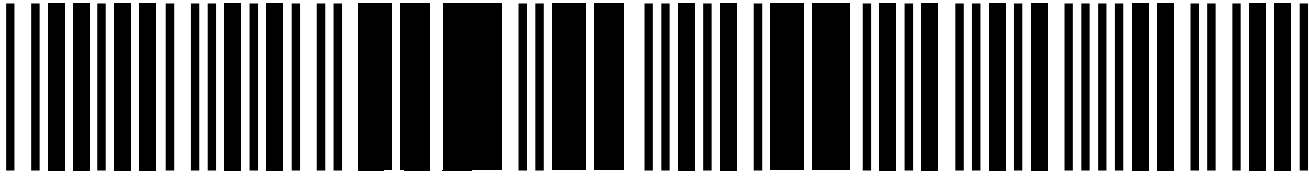
Use this document to complete forms, but do not file this document with your forms.



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: _____

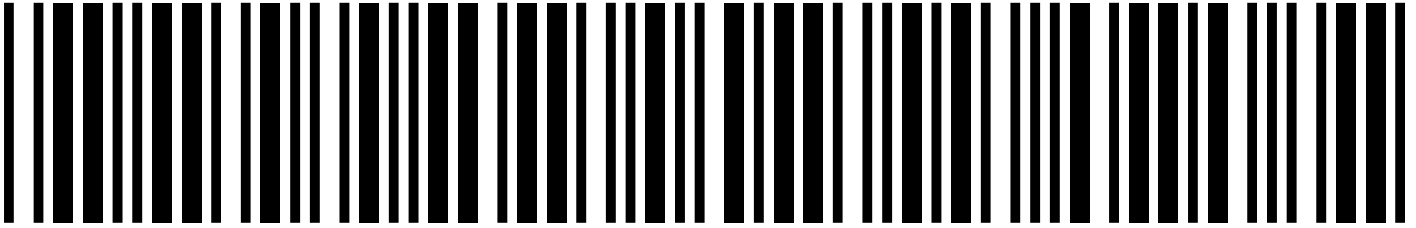
Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____



DOCUMENT SEPARATOR SHEET



Product Delivery Unit

Document Type

Document Title

Document Date

MM/DD/YYYY

Author

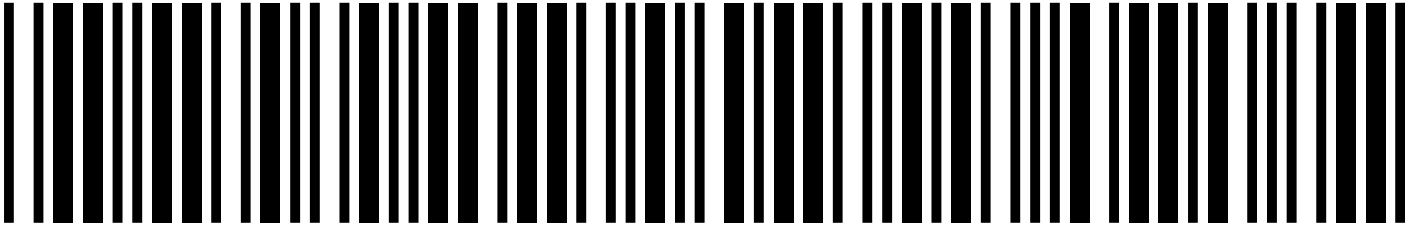
Office Use Only

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

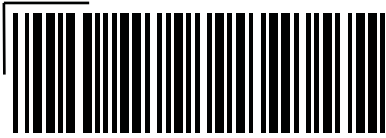
Author

YOUR NAME

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)

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.

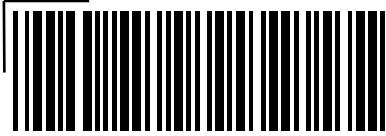
Service of Documents

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 MM/DD/YYYY

End Date DATE RETURNED TO WORK 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): 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.

SAMPLE

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

YOUR SIGNATURE

Applicant Attorney/Representative Signature

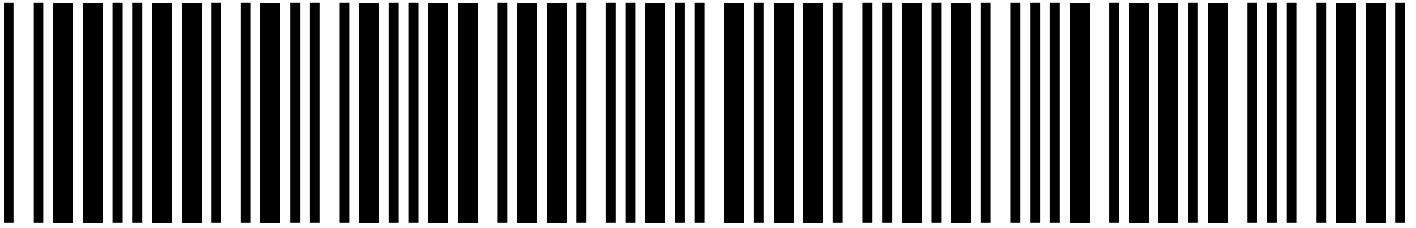
Applicant Signature

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

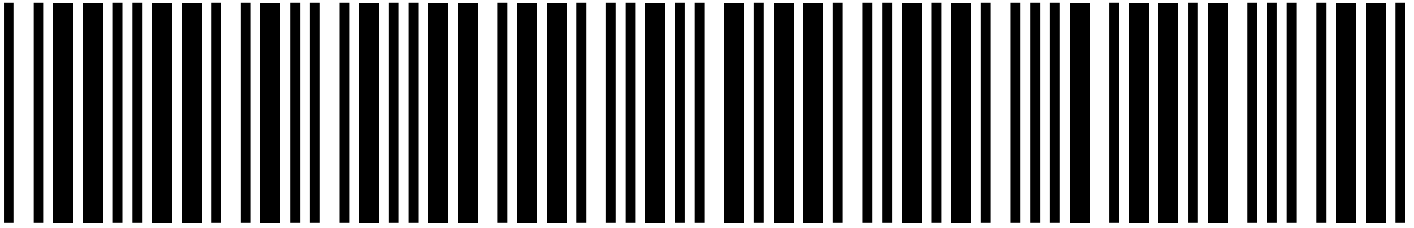
Office Use Only

Received Date

MM/DD/YYYY



DOCUMENT SEPARATOR SHEET



Product Delivery Unit

Document Type

Document Title

Document Date
MM/DD/YYYY

Author

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

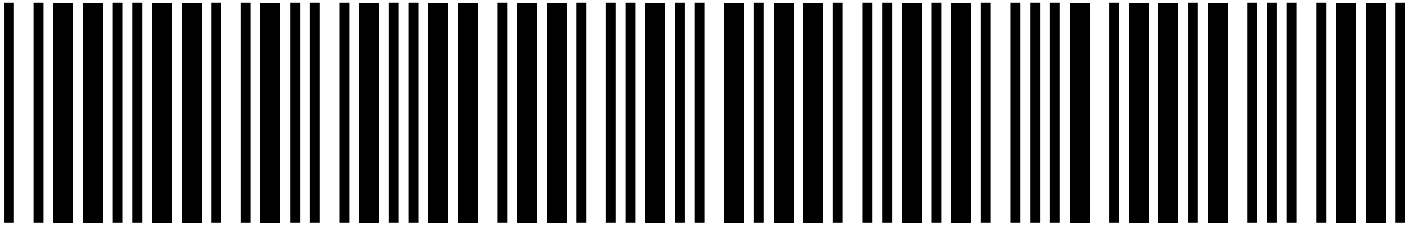
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

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

Type or print name PRINT YOUR NAME

Signature SIGN YOUR NAME

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

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Author

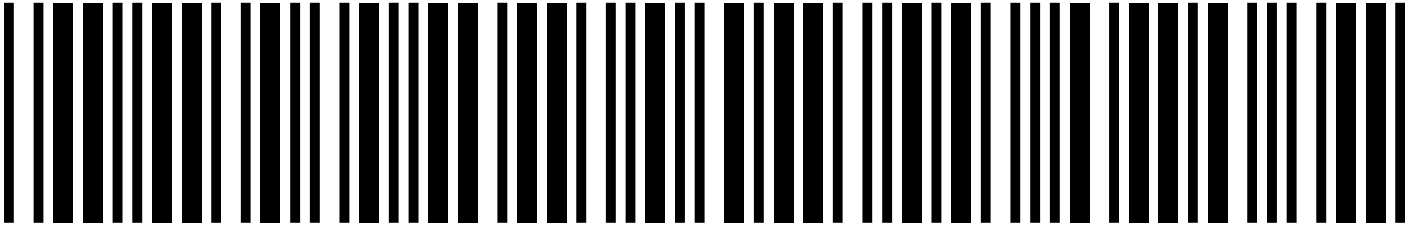
Office Use Only

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Author

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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)

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Date: TODAY'S DATE_____

YOUR SIGNATURE

Signature

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