

## Information & Assistance Unit guide 5

### How to file a declaration of readiness to proceed

File a declaration of readiness to proceed (DOR) to request a conference at your local Workers' Compensation Appeals Board (WCAB) office.

A conference will be set only if you filed an application for adjudication of claim and a WCAB case number has been set up. If you don't have a WCAB case number, you will also need to file an application for adjudication of claim, which opens a WCAB case for you (see I&A guide 4).

Complete the form following the attached sample. Provide the specific information requested about how you tried to resolve the issues. This form can also be completed at

[http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCCAFForm10250\\_1.pdf](http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCCAFForm10250_1.pdf)

When you file the DOR, you should also file all relevant medical reports and records, and all letters from the insurance company about the issues in dispute.

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 Declaration of Readiness to Proceed*)
- ✓ [Declaration of Readiness To Proceed](#)
- ✓ [Document Separator Sheet](#) (*for Proof of Service By Mail*)
- ✓ [Proof of Service By Mail](#)

Keep copies of your filings for your records.

The WCAB will review the DOR. All parties will be notified by mail when a conference is set.

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).

## Information & Assistance Unit guide 5

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 insurance company 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**

**SACRAMENTO, 95834-2962**

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

**BAKERSFIELD, 93301-1929**

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

**SALINAS, 93906-2204**

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

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

409 "K" Street, Room 201  
Information & Assistance Unit **(707) 441-5723**

**SAN BERNARDINO, 92401-1411**

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

**FRESNO, 93721-2219**

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

**SAN DIEGO, 92108-4424**

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

**LONG BEACH, 90802-4339**

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

**SAN FRANCISCO, 94102-7014**

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

**LOS ANGELES, 90013-1105**

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

**SAN JOSE, 95113-1402**

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

**MARINA DEL REY, 90292-6902**

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

**SAN LUIS OBISPO, 93401-8736**

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

**OAKLAND, 94612-1499**

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

**SANTA ANA, 92701-4070**

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

**OXNARD, 93030-7912**

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

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

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

**POMONA, 91768-1653**

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

**SANTA ROSA, 95404-4771**

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

**REDDING, 96002-0940**

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

**STOCKTON, 95202-2314**

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

**RIVERSIDE, 92501-3337**

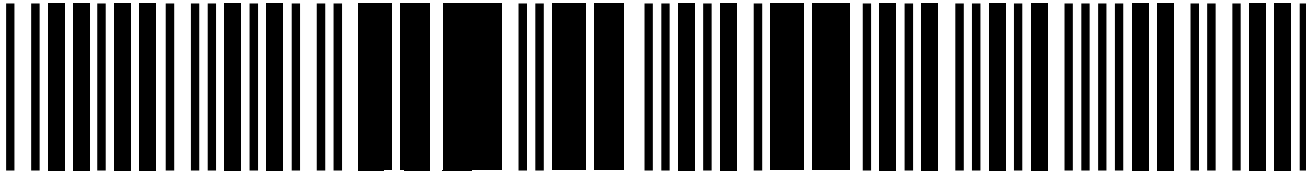
3737 Main Street, Suite 300  
Information & Assistance Unit **(951) 782-4347**

**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)

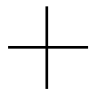
Body Part 1: \_\_\_\_\_

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		

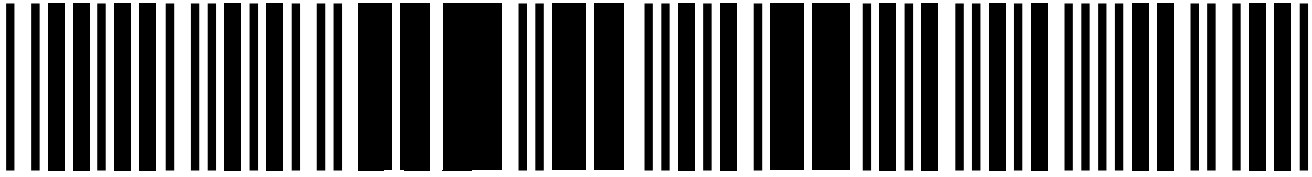
**Use this document to complete forms, but do not file this document with your forms.**



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: \_\_\_\_\_

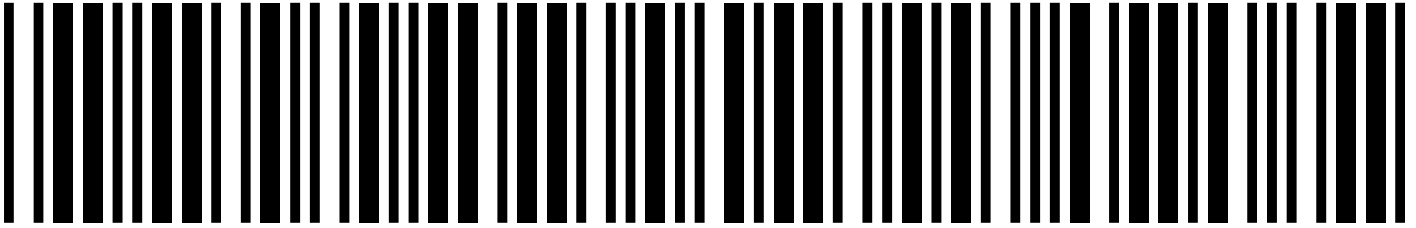
Body Part 2: \_\_\_\_\_

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

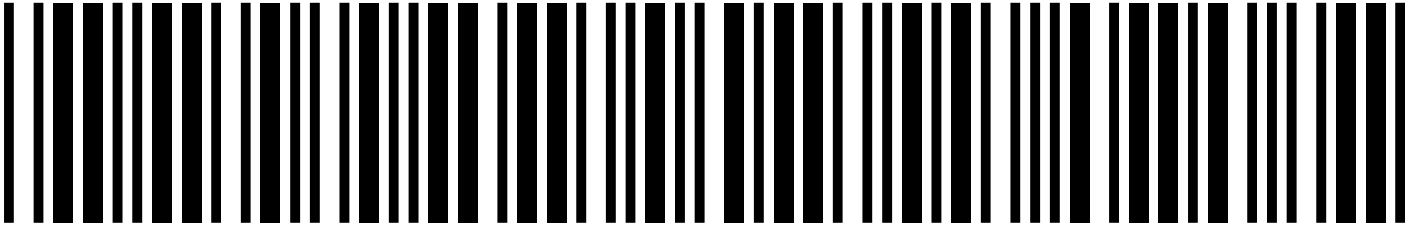
Received Date

\_\_\_\_\_

MM/DD/YYYY



# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

DECLARATION OF READINESS TO PROCEED

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

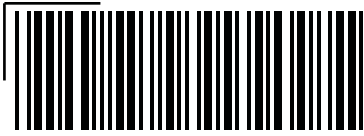
YOUR NAME

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**Office Use Only**

Received Date

MM/DD/YYYY



**STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
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.**

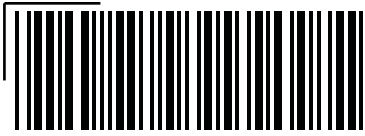
4. The party requiring an interpreter must arrange for the presence of an interpreter, except that the defendant(s) must arrange for the presence of the interpreter if the injured worker is not represented by an attorney.

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

SAMPLE

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.

EAMS CASE NUMBER

Case No.

Applicant

YOUR FIRST NAME

First Name MI

YOUR LAST NAME

Last Name

VS

Employer Information

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

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

- Employee Applicant Defendant Lien Claimant

Declarant requests: (Please Select Only One)

SELECT THE TYPE OF HEARING YOU WANT (SEE PAGE 3, INSTRUCTION SHEET FOR DEFINITIONS)

- 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) NAME OF THE DOCTOR'S REPORT YOU ARE USING date DATE OF REPORT

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:

LIST THE EFFORTS YOU HAVE MADE TO RESOLVE THE DISUPUTE

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 YOUR SIGNATURE

IF YOU DO NOT HAVE AN ATTORNEY, PRINT YOUR NAME

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

YOUR MAILING ADDRESS

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

YOUR PHONE

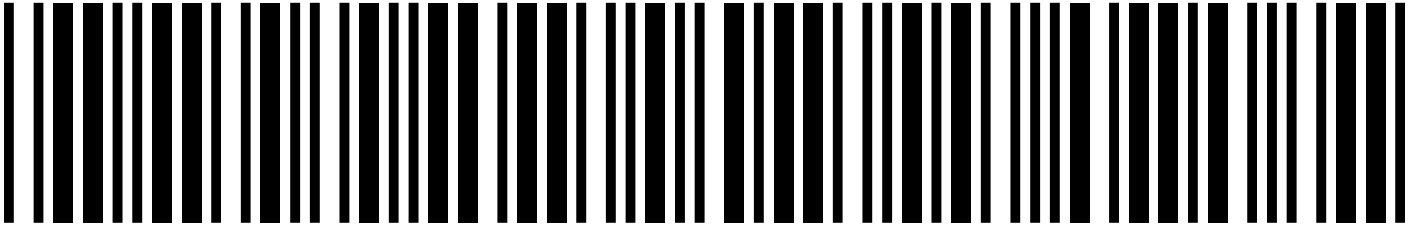
Phone Number

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

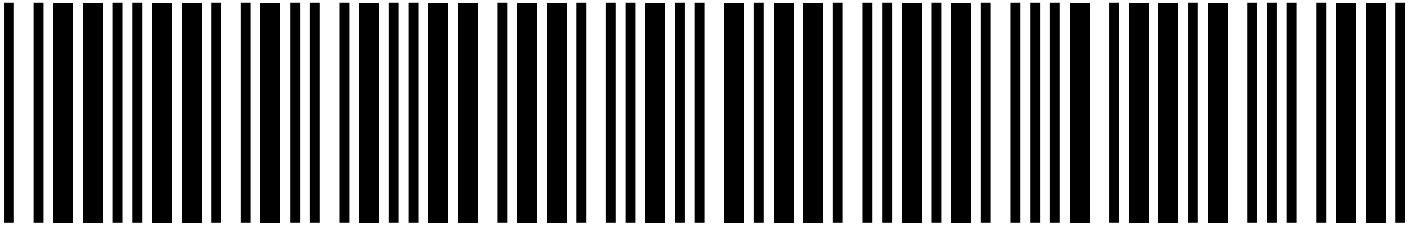
Received Date

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Document 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