

Information & Assistance Unit guide 8

How to file a serious & willful misconduct petition (Labor Code Section 4553)

This petition should be filed if you have been injured because of serious and willful misconduct by your employer.

This petition must be filed within 12 months of the date of injury.

A serious and willful petition can only be filed if you have a pending Workers' Compensation Appeals Board (WCAB) case at your local district office. To open a WCAB case, you must file an application for adjudication of claim (see I&A guide 4). When you are ready to have a WCAB hearing, you must also file a declaration of readiness to proceed (see I&A guide 5).

Serious and willful misconduct can be very difficult to prove. Because of the technical nature of this petition, you may need legal advice. A blank form you can use to write out your petition is attached. Also attached is a sample that may be used as a guide.

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 Petition for increased benefits for Serious & Willful Misconduct)
- ✓ [Petition for Serious & Willful Misconduct](#)
- ✓ [Verification](#)
- ✓ [Document Separator Sheet](#) (for Proof of Service By Mail)
- ✓ [Proof of Service By Mail](#)

Keep copies of your filings for your records.

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.

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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 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

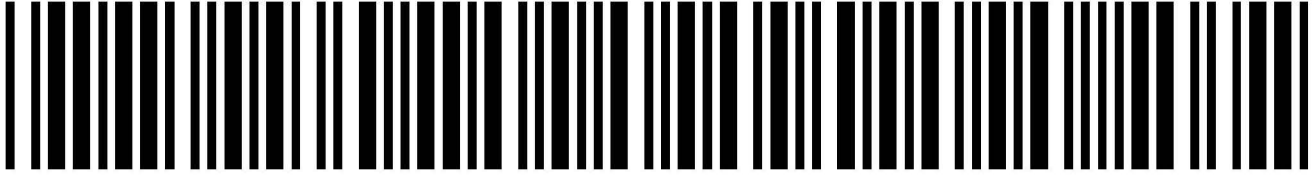
<p><u>ANAHEIM. 92806-2131</u> 1065 North Link, Suite 170 Information & Assistance Unit (714) 414-1801</p>	<p><u>SACRAMENTO, 95834-2962</u> 160 Promenade Circle, Suite 300 Information & Assistance Unit (916) 928-3158</p>
<p><u>BAKERSFIELD. 93301-1929</u> 1800 30th Street, Suite 100 Information & Assistance Unit (661) 395-2514</p>	<p><u>SALINAS. 93906-2204</u> 1880 N Main Street, Suites 100 & 200 Information & Assistance (831) 443-3058</p>
<p><u>FRESNO. 93721-2219</u> 2550 Mariposa Street, Suite 4078 Information & Assistance Unit (559) 445-5355</p>	<p><u>SAN BERNARDINO. 92401-1411</u> 464 W Fourth Street, Suite 239 Information & Assistance Unit (909) 383-4522</p>
<p><u>LODI. 95240-6936</u> 3021 Reynolds Ranch Parkway, Suite 130 Information & Assistance Unit (209) 948-7759</p>	<p><u>SAN DIEGO. 92108-4424</u> 7575 Metropolitan Drive, Suite 202 Information & Assistance Unit (619) 767-2082</p>
<p><u>LONG BEACH. 90810-1870</u> 1500 Hughes Way, Suite C203 Information & Assistance Unit (424) 450-2565</p>	<p><u>SAN FRANCISCO. 94102-7014</u> 455 Golden Gate Avenue, 2nd Floor Information & Assistance Unit (415) 703-5020</p>
<p><u>LOS ANGELES. 90013-1105</u> 320 W 4th Street, 9th Floor Information & Assistance Unit (213) 576-7389</p>	<p><u>SAN JOSE. 95110-3718</u> 224 Airport Parkway, Suite 600 Information & Assistance Unit (408) 277-1292</p>
<p><u>MARINA DEL REY. 90292-6902</u> 4720 Lincoln Boulevard, 2nd and 3rd Floors Information & Assistance Unit (310) 482-3820</p>	<p><u>SAN LUIS OBISPO. 93401-8736</u> 4740 Allene Way, Suite 100 Information & Assistance Unit (805) 596-4159</p>
<p><u>OAKLAND. 94612-1499</u> 1515 Clay Street, 6th Floor Information & Assistance Unit (510) 622-2861</p>	<p><u>SANTA ANA. 92707-7704</u> 2 MacArthur Place, Suite 600 Information & Assistance Unit (714) 942-7576</p>
<p><u>OXNARD. 93030-7912</u> 1901 N Rice Avenue, Suite 100 Information & Assistance Unit (805) 485-3528</p>	<p><u>SANTA BARBARA. 93101-7538</u> 130 E Ortega Street Information & Assistance Unit (805) 568-1390</p>
<p><u>POMONA. 91768-1653</u> 732 Corporate Center Drive Information & Assistance Unit (909) 623-8568</p>	<p><u>SANTA ROSA. 95404-4771</u> 50 "D" Street, Suite 420 Information & Assistance Unit (707) 576-2452</p>
<p><u>REDDING. 96002-0940</u> 250 Hemsted Drive, 2nd Floor, Suite B Information & Assistance Unit (530) 225-2047</p>	<p><u>VAN NUYS. 91401-3370</u> 6150 Van Nuys Boulevard, Suite 105 Information & Assistance Unit (818) 901-5374</p>
<p><u>RIVERSIDE. 92501-3337</u> 3737 Main Street, Suite 300 Information & Assistance Unit (951) 782-4347</p>	



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)

SSN: **YOUR SOCIAL SECURITY NUMBER**

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: _____

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

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: _____



District office codes for place of venue

Legend Abbreviation	Office
AHM	Anaheim
ANA	Santa Ana
BAK	Bakersfield
FRE	Fresno
LAO	Los Angeles
LBO	Long Beach
LOD	Lodi
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
VNO	Van Nuys

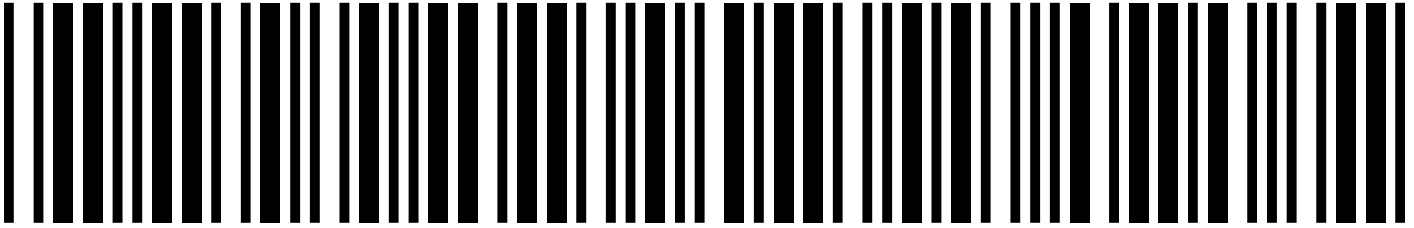
**Use this document to complete forms,
but do not file this document with your forms.**

BODY PART CODES LIST

Code Number	Description
100	Head - not specified
110	Brain
120	Ear - not specified
121	Ear - external
124	Ear - internal including hearing
130	Eye - including optic nerves and vision
140	Face - not specified
141	Jaw - including chin and mandible
144	Mouth - including lips, tongue, throat and taste
145	Teeth
146	Nose - including nasal passages, sinus and smell
148	Face - multiple parts any combination of above parts
149	Face - forehead, cheeks, eyelids
150	Scalp
160	Skull
198	Head - multiple injury any combination of above parts
200	Neck
300	Upper extremities - not specified
310	Arm - above wrist not specified
311	Arm - upper arm humerus
313	Arm - elbow head of radius
315	Arm - forearm radius and ulna
318	Arm - multiple parts any combination of above parts
319	Arm - not specified
320	Wrist
330	Hand - not wrist or fingers
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

Code Number	Description
500	Lower extremities - not specified
510	Legs - above ankles, not specified
511	Thigh femur
513	Knee Patella
515	Lower leg tibia and fibula
518	Leg - multiple parts any combination of above parts
519	Leg - not specified
520	Ankle malleolus
530	Foot not ankle or toe
540	Toes
598	Lower extremities - 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
800	Body system - not specific
801	Circulatory system - heart - other than heart attack, blood, arteries, veins, etc.
802	Circulatory system - Heart attack
810	Digestive system - stomach
820	Excretory system - kidneys, bladder, intestines, etc.
830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
840	Nervous system - not specified
841	Nervous system - Stress
842	Nervous system - Psychiatric/psych
850	Respiratory system - lungs, trachea, etc.
860	Skin dermatitis, etc.
870	Reproductive systems
880	Other body systems
900	COVID-19
999	Unclassified - insufficient information to identify body parts

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

PETITION FOR INCREASED BENEFITS FOR SERIOUS AND WILLFUL MISCONDUCT

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

YOUR NAME

Office Use Only

Received Date

MM/DD/YYYY



Sample

NAME: *your name*
STREET: *your address*
CITY, STATE, ZIP CODE:
TELEPHONE #: *your telephone number*

STATE OF CALIFORNIA WORKERS' COMPENSATION APPEALS BOARD

your name

Applicant,

vs.

your employer

Defendants.

WCAB#: *EAMS/CASE NUMBER*

PETITION FOR BENEFITS FOR SERIOUS
AND WILLFULL MISCONDUCT OF
EMPLOYER PURSUANT TO LABOR
CODE SECTION 4553

Explain in your own words why you feel you are entitled to these benefits

your signature

date mailed

VERIFICATION

STATE OF CALIFORNIA

County of your county

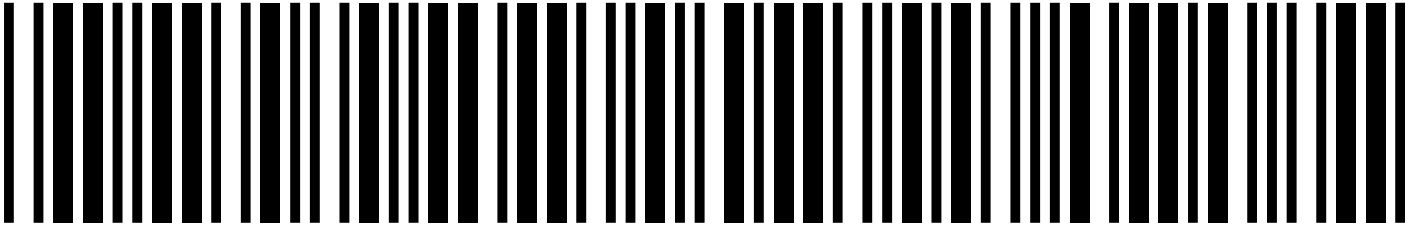
I, the undersigned, say that I am your name , a party to this action. I have read the foregoing **Petition for Benefits for Serious and Willful Misconduct of Employer Pursuant to Labor Code Section 4553** and know the contents thereof, and that the same is true of my own knowledge, except as to the matters which are therein stated upon my information or belief, and as to those matters that I believe to be true.

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

Executed on date mailed at your city , California.

 your signature
Petitioner

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 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