

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.

Information & Assistance Unit guide 8

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

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 30th 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, 2nd Floor
Information & Assistance Unit **(415) 703-5020**

LOS ANGELES, 90013-1105

320 W 4th Street, 9th 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, 2nd and 3rd 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, 6th 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, 2nd 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

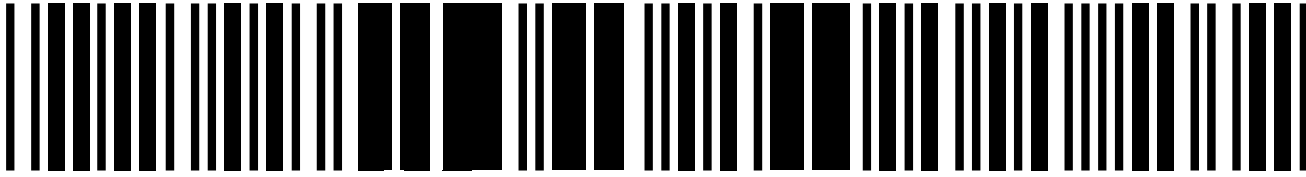
3737 Main Street, Suite 300
Information & Assistance Unit **(951) 782-4347**

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)

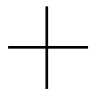
Body Part 1: _____

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>	
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		

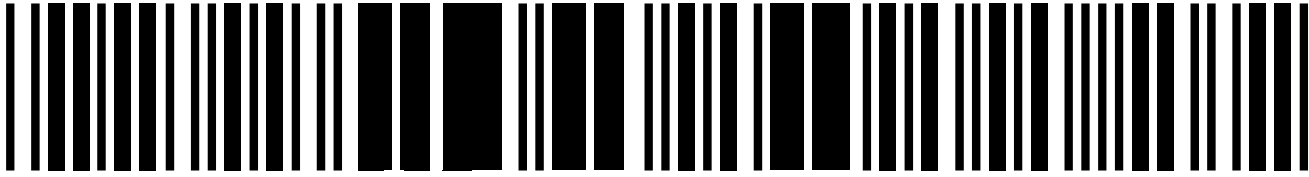
Use this document to complete forms, but do not file this document with your forms.



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: _____

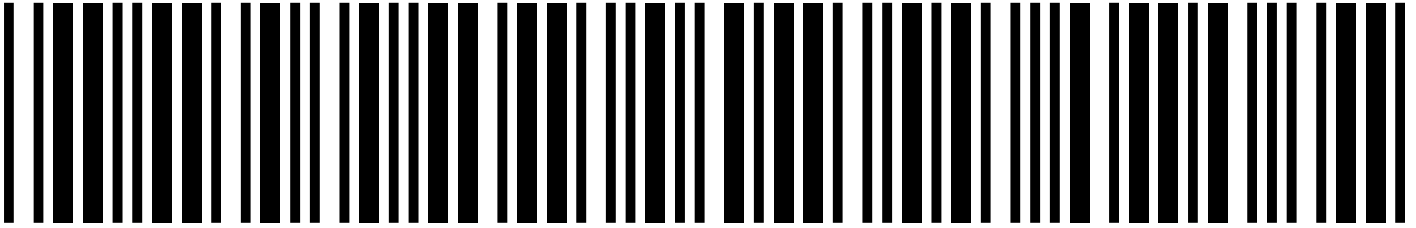
Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____



DOCUMENT SEPARATOR SHEET



Product Delivery Unit

Document Type

Document Title

Document Date

MM/DD/YYYY

Author

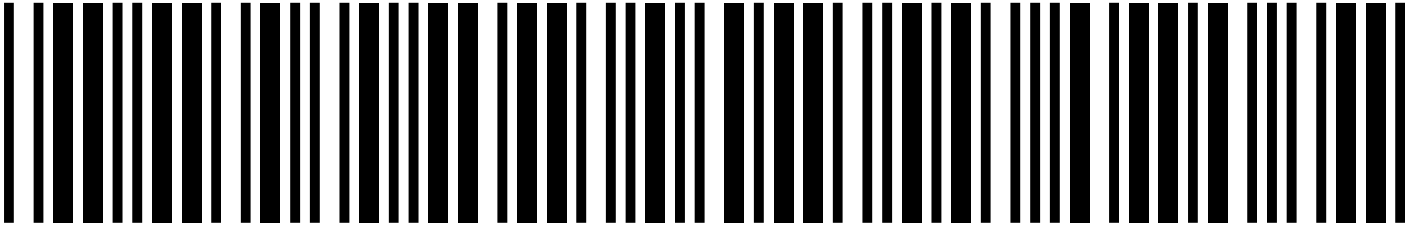
Office Use Only

Received Date

MM/DD/YYYY



DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

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

NAME:

STREET:

CITY, STATE, ZIP CODE:

TELEPHONE #:

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

vs.	Applicant, Defendants.
-----	-------------------------------

WCAB#:

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

your signature

date mailed

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 _____

I, the undersigned, say that I am _____, 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 _____ at _____, California.

Petitioner

April 2014

VERIFICATION

STATE OF CALIFORNIA

County of your county

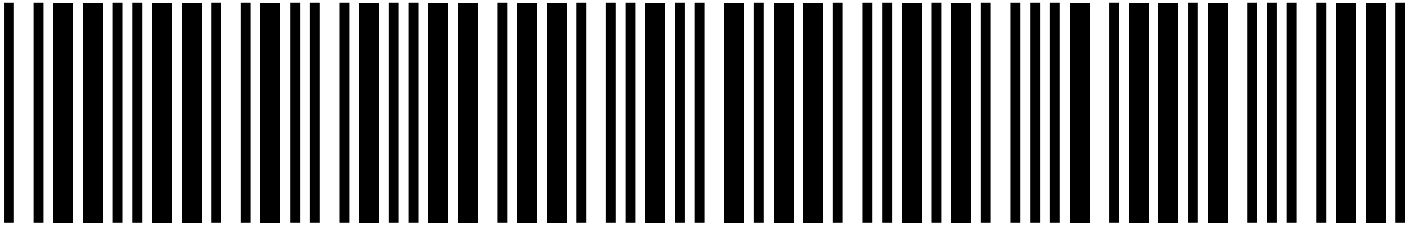
I, the undersigned, say that I am your name , a party to this action. I have read the foregoing **Petition for Benefits for Serious and Willful Misconduct of Employer Pursuant to Labor Code Section 4553** and know the contents thereof, and that the same is true of my own knowledge, except as to the matters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

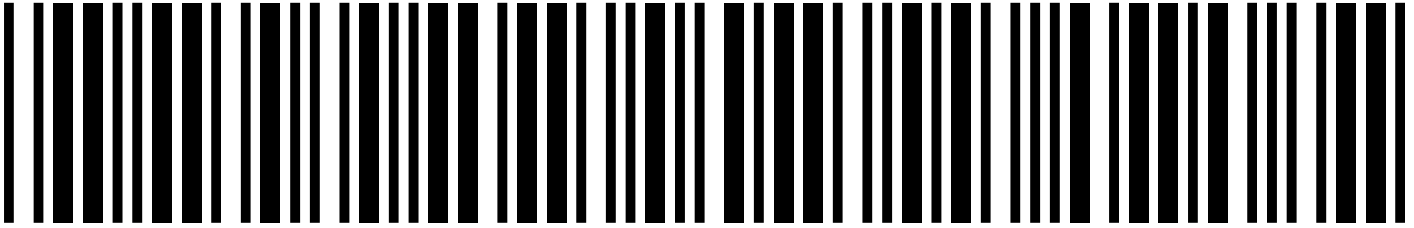
Office Use Only

Received Date

MM/DD/YYYY



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