

## **How to file a lien**

Filing a notice and request for allowance of lien is how you make a claim for payment of money you're owed in a workers' compensation case.

Attached is a lien form. Complete the form. Be sure to sign and date it. This form can also be completed at:

<http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCFORM6.pdf>.

A Workers' Compensation Appeals Board (WCAB) case number must be entered in the top right hand corner of the lien. If there is no WCAB case number, contact the local Information & Assistance (I&A) office.

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 Notice and Request for Allowance of Lien)
- ✓ [Notice and request for allowance of lien](#)
- ✓ [Document Separate Sheet](#) (for 10770.5 Verification)
- ✓ [Lien Verification 10770.5](#)
- ✓ [Document Separate Sheet](#) (for Proof of Service By Mail)
- ✓ [Proof of Service by Mail](#)

There are time limits to file for medical providers and medical-legal lien claimants. Also these parties are limited to jet filing or e-filing. Such liens must be filed:

1. For services provided prior to July 1, 2013, within three years from the last date services were provided.
2. For services provided after July 1, 2013, within 18 months from the last date services were provided.

Keep copies of your filings for your records.

## Information & Assistance Unit Guide 10

All documents filed with the WCAB must include a document cover sheet and document separator sheet. Please see I&A guides 17 and 18 to learn how to complete these forms. In addition all forms must be typed or handwritten in block letters to insure legibility. Additional form instructions can be found on the EAMS OCR handbook at:

[http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS\\_OCR%20handbook.pdf](http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf).

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

If you do not have the name and address of your insurance company to complete a form, please link to this site <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 handbook for further instructions.

# WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

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**ANAHEIM, 92806-2131**

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

**BAKERSFIELD, 93301-1929**

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

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

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

**MARINA DEL REY, 90292-6902**

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

**OAKLAND, 94612-1499**

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

**OXNARD, 93030-7912**

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

**POMONA, 91768-1653**

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

**REDDING, 96002-0940**

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

**RIVERSIDE, 92501-3337**

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

**SACRAMENTO, 95834-2962**

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

**SALINAS, 93906-2204**

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

**SAN BERNARDINO, 92401-1411**

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

**SAN DIEGO, 92108-4424**

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

**SAN FRANCISCO, 94102-7014**

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

**SAN JOSE, 95113-1402**

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

**SAN LUIS OBISPO, 93401-8736**

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

**SANTA ANA, 92701-4070**

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

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

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

**SANTA ROSA, 95404-4771**

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

**STOCKTON, 95202-2314**

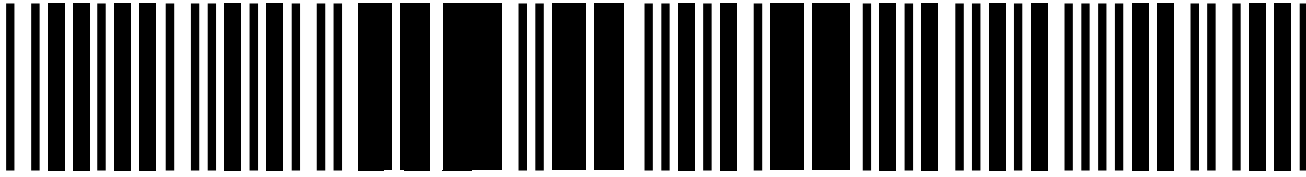
31 E Channel Street, Suite 344  
Information & Assistance Unit (209) 948-7980

**VAN NUYS, 91401-3370**

6150 Van Nuys Boulevard, Suite 105  
Information & Assistance Unit (818) 901-5374

STATE OF CALIFORNIA  
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET



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

More than 15 Companion Cases

Date:(MM/DD/YYYY)

SSN: \_\_\_\_\_

Specific Injury

Case Number 1

Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)  
(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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

**Please check unit to be filed on ( check only one box )**

ADJ  DEU  SIF  UEF  SAU  INT  RSU

**Companion Cases**

Specific Injury

Case Number 2

Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)  
(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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

Specific Injury

Case Number 3

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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

Specific Injury

Case Number 4

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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



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

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

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

Specific Injury

Case Number 5

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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



Specific Injury

Case Number 6

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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

Specific Injury

Case Number 7

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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

Specific Injury

Case Number 8

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

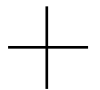
Body Part 1: \_\_\_\_\_

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

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

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

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



Specific Injury

Case Number 9

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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

Specific Injury

Case Number 10

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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



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

Specific Injury

Case Number 11

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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



Specific Injury

Case Number 12

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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

Specific Injury

Case Number 13

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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



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

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

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

Specific Injury

Case Number 14

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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





Specific Injury

Case Number 15

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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



Specific Injury

Case Number 16

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

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

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

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



## District office codes for place of venue

<i>Legend</i>	
<b>Abbreviation</b>	<b>Office</b>
AHM	Anaheim
ANA	Santa Ana
BAK	Bakersfield
EUR	Eureka*
FRE	Fresno
LAO	Los Angeles
LBO	Long Beach
MDR	Marina del Rey
OAK	Oakland
OXN	Oxnard
POM	Pomona
RDG	Redding
RIV	Riverside
SAC	Sacramento
SAL	Salinas
SBA	Santa Barbara**
SBR	San Bernardino
SDO	San Diego
SFO	San Francisco
SJO	San Jose
SLO	San Luis Obispo
SRO	Santa Rosa
STK	Stockton
VNO	Van Nuys

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

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

## Body Part Code List

The body part codes listed below are used to complete forms that require the listing of the part of the body that is in issue. Please do not file this document with your forms.

100	Head - not specified	500	Lower extremities - not specified
110	Brain	510	Legs - above ankles, not specified
120	Ear - not specified	511	Thigh femur
121	Ear - external	513	Knee Patella
124	Ear - internal including hearing	515	Lower leg tibia and fibula
130	Eye - including optic nerves and vision	518	Leg - multiple parts any combination of above parts
140	Face - not specified	519	Leg - not specified
141	Jaw - including chin and mandible	520	Ankle malleolus
144	Mouth - including lips, tongue, throat and taste	530	Foot not ankle or toe
145	Teeth	540	Toes
146	Nose - including nasal passages, sinus and smell	598	Lower extremities - multiple parts any combination of above parts
148	Face - multiple parts any combination of above parts	700	Multiple parts more than five major parts use only in fifth position of listing of body parts
149	Face - forehead, cheeks, eyelids	800	Body system - not specific
150	Scalp	801	Circulatory system - heart -other than heart attack, blood, arteries, veins, etc.
160	Skull	802	Circulatory system - Heart attack
198	Head - multiple injury any combination of above parts	810	Digestive system - stomach
200	Neck	820	Excretory system - kidneys, bladder, intestines, etc
300	Upper extremities - not specified	830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
310	Arm - above wrist not specified	840	Nervous system - not specified
311	Arm - upper arm humerus	841	Nervous system - stress
313	Arm - elbow head of radius	842	Nervous system - Psychiatric/psych
315	Arm -forearm radius and ulna	850	Respiratory system - lungs, trachea, etc.
318	Arm - multiple parts any combination of above parts	860	Skin dermatitis, etc.
319	Arm - not specified	870	Reproductive systems
320	Wrist	880	Other body systems
330	Hand - not wrist or fingers	999	Unclassified - insufficient information to identify body parts
340	Fingers		
398	Upper extremities - multiple parts any combination of above parts		
400	Trunk - not specified		
410	Abdomen - including internal organs and groin		
411	Hernia		
420	Back - including back muscles, spine and spinal cord		
430	Chest - including ribs, breast bone and internal organs of the chest		
440	Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks		
450	Shoulders - scapula and clavicle		
498	Trunk - use for side; multiple parts any combination of above parts		

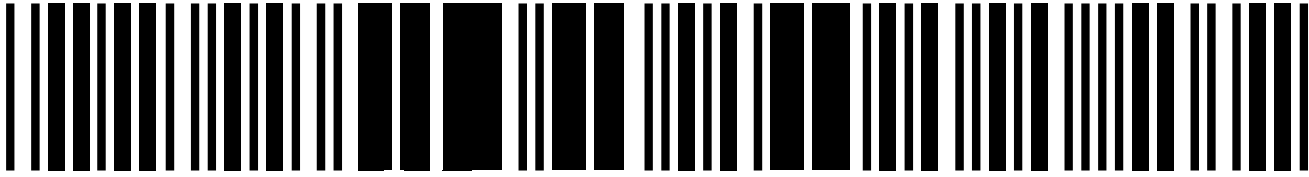
**Use this document to complete forms, but do not file this document with your forms.**



STATE OF CALIFORNIA  
DWC DISTRICT OFFICE

**SAMPLE**

DOCUMENT COVER SHEET



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

More than 15 Companion Cases

**TODAY'S DATE**

Date:(MM/DD/YYYY)

**YOUR SOCIAL SECURITY NUMBER**

SSN:

**EAMS CASE NUMBER**

Case Number 1

Specific Injury

**DATE OF INJURY**

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

**IF NEW CASE LEAVE BLANK**

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

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

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

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

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

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

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

**Please check unit to be filed on ( check only one box )**

ADJ     DEU     SIF     UEF     SAU     INT     RSU

**Companion Cases**

Specific Injury

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

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

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

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

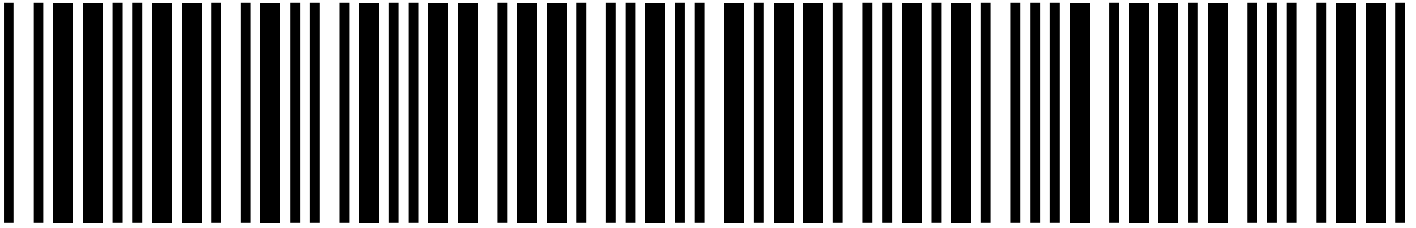
Body Part 2: \_\_\_\_\_

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

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



# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

\_\_\_\_\_

Document Type

\_\_\_\_\_

Document Title

\_\_\_\_\_

Document Date

\_\_\_\_\_

MM/DD/YYYY

Author

\_\_\_\_\_

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## Office Use Only

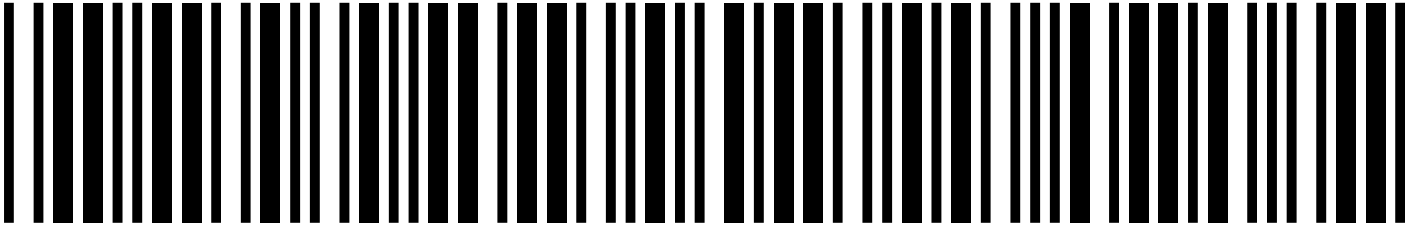
Received Date

\_\_\_\_\_

MM/DD/YYYY



# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LIENS AND BILLS

Document Title

NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

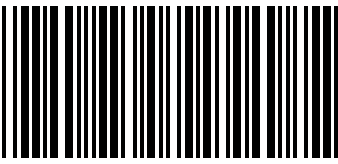
IF YOU ARE THE INJURED WORKER, USE YOUR NAME.  
IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OR LAW FIRM -- USE YOUR UNIFORM ASSIGNED NAME.

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**Office Use Only**

Received Date

MM/DD/YYYY



**STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN**



Date Of Original Lien: \_\_\_\_\_  
MM/DD/YYYY

Original Lien

Amended Lien

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

**(Choose only one)**

a specific injury on \_\_\_\_\_  
(DATE OF INJURY: MM/DD/YYYY)

a cumulative injury which began on \_\_\_\_\_ and ended on \_\_\_\_\_  
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

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

(DATE OF BIRTH: MM/DD/YYYY)

**Injured Worker:**

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

MI

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

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

City \_\_\_\_\_

State

Zip Code

**Attorney/Representative for Injured Worker:**

Name \_\_\_\_\_

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

City \_\_\_\_\_

State

Zip Code

**Lien Claimant (Completion of this section is required):**

Name of Organization filing lien (for individual lien claimants, leave blank) \_\_\_\_\_

First Name of Individual filing lien(organizational lien claimants, leave blank) \_\_\_\_\_

Last Name of Individual filing lien(organizational lien claimants, leave blank) \_\_\_\_\_

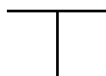
Address/PO Box ( Please leave blank spaces between numbers, names or words) \_\_\_\_\_

City \_\_\_\_\_

State

Zip Code

Phone \_\_\_\_\_

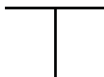


**Lien Claimant's Attorney/Representative, if any**

Law Firm/Attorney

Non-Attorney Representative

Lien Claimant not represented



\_\_\_\_\_  
Lien Claimant Law Firm/Representative

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

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

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

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone

**Employer**

\_\_\_\_\_  
Name

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

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

**Insurance Carrier or Claims Administrator**

\_\_\_\_\_  
Name

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

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

**Employer or Claims Administrator Attorney/Representative (if known)**

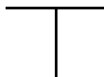
\_\_\_\_\_  
Name

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

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code





The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of \$ \_\_\_\_\_ against any amount now due or which may hereafter become payable as compensation to the above-named employee on account of the above-claimed injury.

Total Lien Amount

**This request and claim for lien is for (mark appropriate box):**

- A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).)
- Reasonable expense incurred by or on behalf of the injured employee for medical-legal expenses. (Labor Code § 4903 (b).)
- The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)
- The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- The reasonable fee for interpreter's services performed on \_\_\_\_\_ 20 \_\_\_\_ . (Labor Code § 4600 (f).)
- The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)
- Other Lien(s): Specify nature and statutory basis.

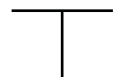
**NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED**

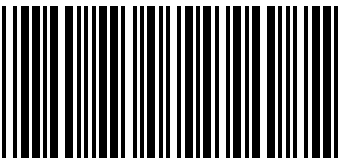
- A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

\_\_\_\_\_  
(Signature of Attorney/Representative for Lien Claimant)

\_\_\_\_\_  
(Signature of Lien Claimant)

\_\_\_\_\_  
Date (MM/DD/YYYY)





**STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN**

**SAMPLE**

Date Of Original Lien: \_\_\_\_\_  
MM/DD/YYYY

Original Lien

Amended Lien

**EAMS CASE NUMBER**

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

**(Choose only one)**

a specific injury on \_\_\_\_\_  
(DATE OF INJURY: MM/DD/YYYY)

a cumulative injury which began on \_\_\_\_\_ and ended on \_\_\_\_\_  
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

**INJURED WORKER'S SSN**

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

(DATE OF BIRTH: MM/DD/YYYY)

**Injured Worker:**

**INJURED WORKER'S FIRST NAME**

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

**INJURED WORKER'S LAST NAME**

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

**INJURED WORKER'S ADDRESS**

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

**INJURED WORKER'S CITY**

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

**Attorney/Representative for Injured Worker:**

**NAME OF INJURED WORKER'S ATTORNEY**

Name \_\_\_\_\_

**ATTORNEY ADDRESS**

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

**ATTORNEY CITY**

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

**Lien Claimant (Completion of this section is required):**

**NAME OF ORGANIZATION FILING LIEN**

Name of Organization filing lien (for individual lien claimants, leave blank)

**FIRST NAME OF CONTACT**

First Name of Individual filing lien(organizational lien claimants, leave blank)

**LAST NAME OF CONTACT**

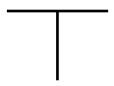
Last Name of Individual filing lien(organizational lien claimants, leave blank)

**ORGANIZATION ADDRESS**

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

**ORGANIZATION CITY**

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



**Lien Claimant's Attorney/Representative, if any**

Law Firm/Attorney       Non-Attorney Representative       Lien Claimant not represented

**LIEN CLAIMANT LAW FIRM OR REPRESENTATIVE - USE UNIFORM ASSIGNED NAME**

Lien Claimant Law Firm/Representative

**REPRESENTATIVE FIRST NAME**

First Name

**REPRESENTATIVE LAST NAME**

Last Name

**LAW FIRM OR REPRESENTATIVE ADDRESS**

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

**LAW FIRM OR REPRESENTATIVE CITY**

City

State

Zip Code

**LAW FIRM OR REPRESENTATIVE PHONE**

Phone

**Employer**

**NAME OF COMPANY INJURED WORKER WAS WORKING FOR**

Name

**COMPANY ADDRESS**

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

**COMPANY CITY**

City

State

Zip Code

**Insurance Carrier or Claims Administrator**

**CLAIMS ADMINISTRATOR - USE UNIFORM ASSIGNED NAME**

Name

**ADMINISTRATOR ADDRESS**

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

**ADMINISTRATOR CITY**

City

State

Zip Code

**Employer or Claims Administrator Attorney/Representative (if known)**

**ADMINISTRATOR LAW FIRM - USE UNIFORM ASSIGNED NAME**

Name

**ADMINISTRATOR LAW FIRM ADDRESS**

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

**ADMINISTRATOR LAW FIRM CITY**

City

State

Zip Code

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of \$ \_\_\_\_\_ against any amount now due or which may hereafter become payable as compensation to the above-named employee on account of the above-claimed injury.

Total Lien Amount

SELECT ONE OR MORE REASONS

This request and claim for lien is for (mark appropriate box):

- A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).)
- Reasonable expense incurred by or on behalf of the injured employee for medical-legal expenses. (Labor Code § 4903 (b).)
- The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)
- The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- The reasonable fee for interpreter's services performed on \_\_\_\_\_ 20 \_\_\_\_ . (Labor Code § 4600 (f).)
- The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)
- Other Lien(s): Specify nature and statutory basis.

[Empty box for itemized statement justifying the lien]

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

- A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

TODAY'S DATE

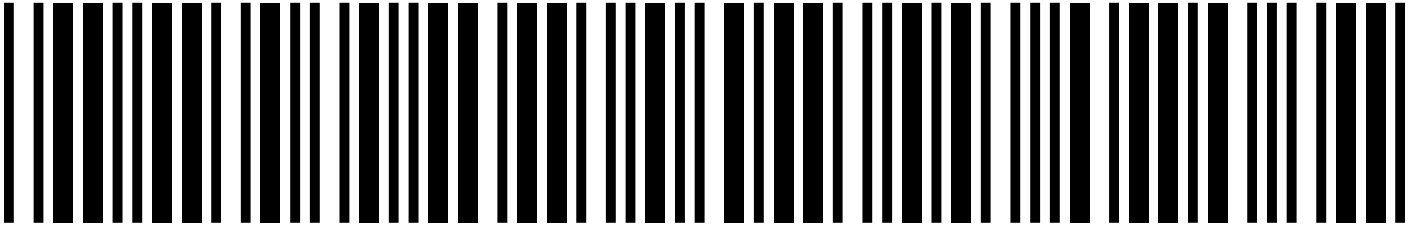
\_\_\_\_\_  
(Signature of Attorney/Representative for Lien Claimant)

\_\_\_\_\_  
(Signature of Lien Claimant)

\_\_\_\_\_  
Date (MM/DD/YYYY)



# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

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Document Type

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Document Title

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Document Date

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MM/DD/YYYY

Author

\_\_\_\_\_

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## Office Use Only

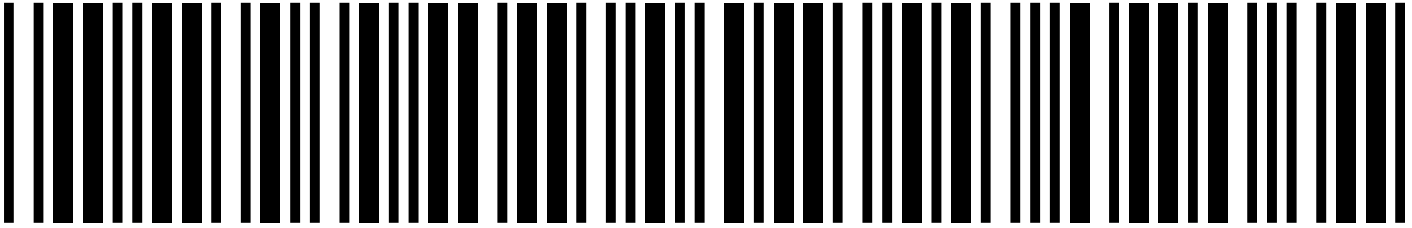
Received Date

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MM/DD/YYYY



# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

10770.5 VERIFICATION

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

IF YOU ARE THE INJURED WORKER, USE YOUR NAME.  
IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OR LAW FIRM -- USE YOUR UNIFORM ASSIGNED NAME.

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**Office Use Only**

Received Date

MM/DD/YYYY



## CCR 10770.5 Verification to Filing of Lien Claim

A lien claim is being filed because:

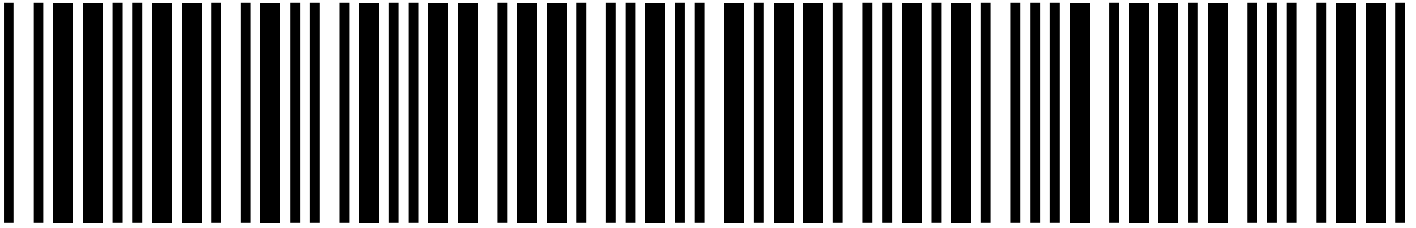
- \_\_\_\_\_ Sixty days have elapsed since the date of acceptance or rejection of liability for the claim, or the time provided for investigation of liability pursuant of Labor Code Section 5402(b) has elapsed, whichever is earlier.
- \_\_\_\_\_ The time provided for payment of medical treatment bills pursuant to Labor Code section 4603.2 has elapsed.
- \_\_\_\_\_ The time provided for payment of medical-legal expenses pursuant to Labor Code section 4622 has elapsed.

I declare under penalty of perjury under the laws of the State of California that one of the time periods set forth in Rule 10770.5(a) has elapsed and, if an application for adjudication is being filed, that venue is proper as set forth in Rule 10770.5(b) and that I have made a diligent search and have determined that no adjudication case number exists for the same injured worker and the same date of injury. In determining that no adjudication case number exists for the same injured worker and the same date of injury, I have made a diligent search consisting of the following efforts (specify):

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

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Document Type

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Document Title

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Document Date

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MM/DD/YYYY

Author

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## Office Use Only

Received Date

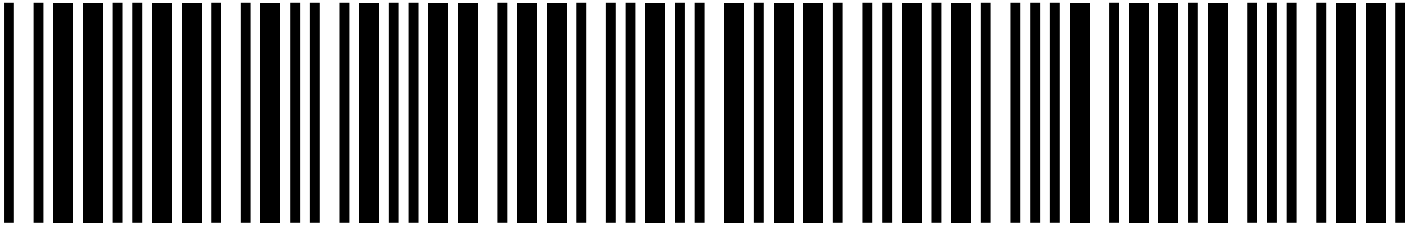
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Document Type

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