Information & Assistance Unit guide 12

How to file a petition for reconsideration

File a petition for reconsideration to appeal a decision by a workers' compensation judge.

The local district office of the Workers' Compensation Appeals Board (WCAB) that issued the decision must get your petition within 20 days from the date the decision was issued. If the judge's decision was mailed to your residence in California, the local district office must receive your petition within 25 days.

You'll find the date the decision was issued near the judge's signature.

The attached petition lists the five reasons for appealing a judge's decision. Strike out items that do not apply to your case. Be sure to cover every item in the decision you disagree with and include a full explanation. You may attach more sheets of paper if needed.

Complete both pages of the petition. Follow the attached sample. Be sure to sign and date the form. Please note there are three signature lines.

Send the original of your petition to the local WCAB office that issued the decision 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 Reconsideration)
- ✓ Petition for Reconsideration
- ✓ 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 12

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 PacifiCenter Drive, Suite 170
Information & Assistance Unit **(714) 414-1800**

BAKERSFIELD, 93301-1929
1800 30th Street, Suite 100
Information & Assistance Unit **(661) 395-2514**

EUREKA, 95501-0481 * Satellite office *
409 "K" Street, Room 201
Information & Assistance Unit **(707) 441-5723**

FRESNO, 93721-2219
2550 Mariposa Street, Suite 4078
Information & Assistance Unit **(559) 445-5355**

LONG BEACH, 90802-4339
300 Oceangate Street, Suite 200
Information & Assistance Unit **(562) 590-5240**

LOS ANGELES, 90013-1105
320 W 4th Street, 9th Floor
Information & Assistance Unit **(213) 576-7389**

MARINA DEL REY, 90292-6902
4720 Lincoln Boulevard, 2nd and 3rd floors
Information & Assistance Unit **(310) 482-3858**

OAKLAND, 94612-1499
1515 Clay Street, 6th Floor
Information & Assistance Unit **(510) 622-2861**

OXNARD, 93030-7912
1901 N Rice Avenue, Suite 100
Information & Assistance Unit **(805) 485-3528**

POMONA, 91768-1653
732 Corporate Center Drive
Information & Assistance Unit **(909) 623-8568**

REDDING, 96002-0940
250 Hemsted Drive, 2nd Fl, Ste. B
Information & Assistance Unit **(530) 225-2047**

RIVERSIDE, 92501-3337
3737 Main Street, Suite 300
Information & Assistance Unit **(951) 782-4347**

SACRAMENTO, 95834-2962
160 Promenade Circle, Suite 300
Information & Assistance Unit **(916) 928-3158**

SALINAS, 93906-2204
1880 N Main Street, Suites 100 & 200
Information & Assistance **(831) 443-3058**

SAN BERNARDINO, 92401-1411
464 W Fourth Street, Suite 239
Information & Assistance Unit **(909) 383-4522**

SAN DIEGO, 92108-4424
7575 Metropolitan Drive, Suite 202
Information & Assistance Unit **(619) 767-2082**

SAN FRANCISCO, 94102-7014
455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit **(415) 703-5020**

SAN JOSE, 95113-1402
100 Paseo de San Antonio, Suite 241
Information & Assistance Unit **(408) 277-1292**

SAN LUIS OBISPO, 93401-8736
4740 Allene Way, Suite 100
Information & Assistance Unit **(805) 596-4159**

SANTA ANA, 92701-4070
605 W Santa Ana Boulevard, Bldg 28, Suite 451
Information & Assistance Unit **(714) 558-4597**

SANTA BARBARA, 93101-7538 * Satellite office *
130 E Ortega St.
Information & Assistance Unit **(805) 568-1390**

SANTA ROSA, 95404-4771
50 "D" Street, Suite 420
Information & Assistance Unit **(707) 576-2452**

STOCKTON, 95202-2314
31 E Channel Street, Suite 344
Information & Assistance Unit **(209) 948-7980**

VAN NUYS, 91401-3370
6150 Van Nuys Boulevard, Suite 105
Information & Assistance Unit **(818) 901-5374**

Rev. 11/18

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 ☐

_____ SSN: _____

Date:(MM/DD/YYYY)

☐ 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

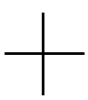
Case Number 16 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(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

Legend

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.

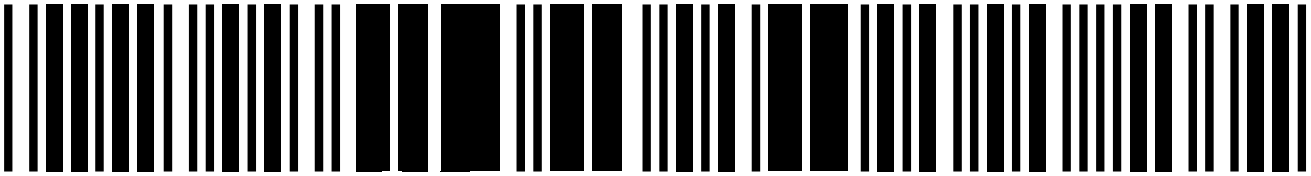
100	Head - not specified
110	Brain
120	Ear - not specified
121	Ear - external
124	Ear - internal including hearing
130	Eye - including optic nerves and vision
140	Face - not specified
141	Jaw - including chin and mandible
144	Mouth - including lips, tongue, throat and taste
145	Teeth
146	Nose - including 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
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
999	Unclassified - insufficient information to identify body 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)

SSN: YOUR SOCIAL SECURITY NUMBER

EAMS CASE NUMBER

Case Number 1

☐ Specific Injury

☐ Cumulative Injury

DATE OF 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

Body Part 1: _____ ← USE CODE FROM BODY PART CODE LIST, SEE PAGE 8

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: _____

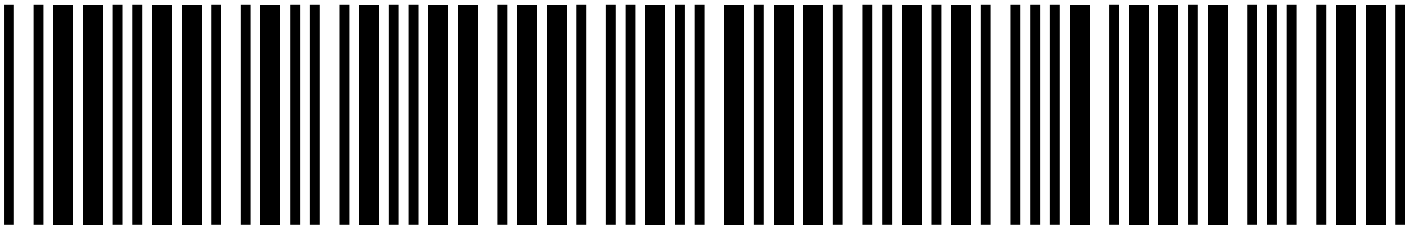
Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

DOCUMENT SEPARATOR SHEET



Product Delivery Unit _____

Document Type _____

Document Title _____

Document Date _____
MM/DD/YYYY

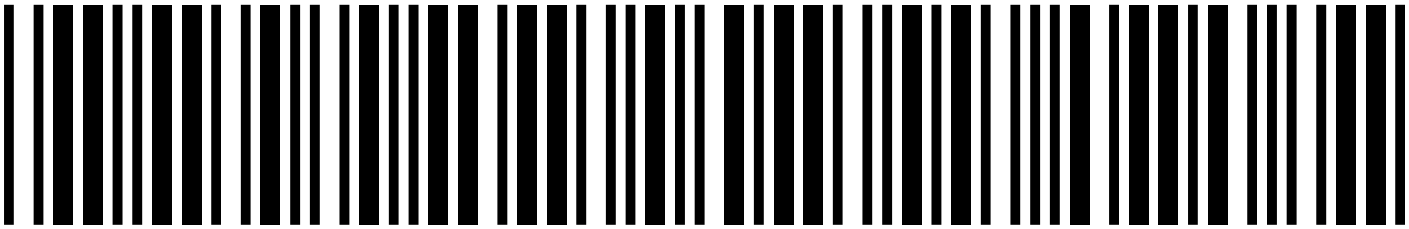
Author _____

Office Use Only

Received Date _____
MM/DD/YYYY

SAMPLE

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: PETITION FOR RECONSIDERATION

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date: _____
MM/DD/YYYY

STATE OF CALIFORNIA
Department of Industrial Relations
Division of Workers' Compensation
WORKERS' COMPENSATION APPEALS BOARD

	)	**Case No.**
	)	
	)	
Applicant,	)	
vs.	)	**Petition for Reconsideration**
	)	
	)	
	)	
	)	
Defendants	)	

A decision was filed in the above-entitled case on _____.

The . is aggrieved by said decision and hereby petitions for reconsideration upon the following grounds: (strike out items not applicable)

1. By the order, decision or award, the Board acted without or in excess of its powers.
2. The order, decision, or award was procured by fraud.
3. The evidence does not justify the findings of fact.
4. Petitioner has discovered new evidence material to him which he could not with reasonable diligence have discovered and produced at the hearing.
5. The findings of fact do not support the order, decision or award.

In support of the above, petitioner gives the following details, including a statement of facts upon which petitioner relies and a discussion of the law applicable thereto:

WHEREFORE, Petitioner requests that reconsideration be granted; that further proceedings be had; and that decision be made to give petitioner all the benefits to which he is entitled under the Labor Code of the State of California, including the relief requested herein.

_____ _____
Attorney for Petitioner Petitioner

STATE OF CALIFORNIA)
) vs.
County of _____)

I, the undersigned, say that I am _____

_____
in the above-entitled action. I have read the foregoing petition for reconsideration 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 it to be true.

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

Executed on _____, 20 ____ at _____ California.

_____
Petitioner

NOTE: If verification is by attorney or officer of a corporation it must comply with Section 446 Code of Civil Procedure.)

Copy mailed to:
Date of Mailing:

By: _____
(Signature)

SAMPLE

STATE OF CALIFORNIA
Department of Industrial Relations
Division of Workers' Compensation
WORKERS' COMPENSATION APPEALS BOARD

YOUR NAME

Applicant,

vs.

YOUR EMPLOYER AND INSURANCE COMPANY

Defendants

Case No. EAMS/WCAB

Petition for Reconsideration

A decision was filed in the above-entitled case on DATE THE JUDGE'S DECISION WAS ISSUED

The YOUR NAME is aggrieved by said decision and hereby petitions for reconsideration upon the following grounds: (strike out items not applicable)

1. By the order, decision or award, the Board acted without or in excess of its powers.
2. The order, decision, or award was procured by fraud.
3. The evidence does not justify the findings of fact.
4. Petitioner has discovered new evidence material to him which he could not with reasonable diligence have discovered and produced at the hearing.
5. The findings of fact do not support the order, decision or award.

In support of the above, petitioner gives the following details, including a statement of facts upon which petitioner relies and a discussion of the law applicable thereto:

COMPLETELY DESCRIBE YOUR DISAGREEMENT WITH THE JUDGE'S DECISION.
BE SURE TO INCLUDE YOUR REASON(S) WHY THE DECISION SHOULD BE CHANGED.

WHEREFORE, Petitioner requests that reconsideration be granted; that further proceedings be had; and that decision be made to give petitioner all the benefits to which he is entitled under the Labor Code of the State of California, including the relief requested herein.

YOUR SIGNATURE

_____ _____

Attorney for Petitioner Petitioner

STATE OF CALIFORNIA)
) vs.
County of YOUR COUNTY)

I, the undersigned, say that I am YOUR NAME

_____

in the above-entitled action. I have read the foregoing petition for reconsideration 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 it to be true.

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

Executed on DATE, 20 ____ at YOUR CITY California.

YOUR SIGNATURE

_____

Petitioner

NOTE: If verification is by attorney or officer of a corporation it must comply with Section 446 Code of Civil Procedure.)

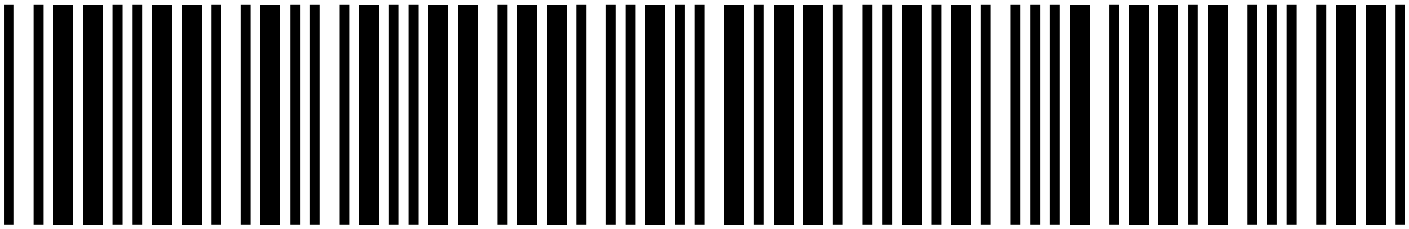
Copy mailed to: LIST NAME AND ADDRESS OF ALL PARTIES INVOLVED IN YOUR CASE.

Date of Mailing: DATE MAILED

By: YOUR SIGNATURE

(Signature)

DOCUMENT SEPARATOR SHEET



Product Delivery Unit _____

Document Type _____

Document Title _____

Document Date _____
MM/DD/YYYY

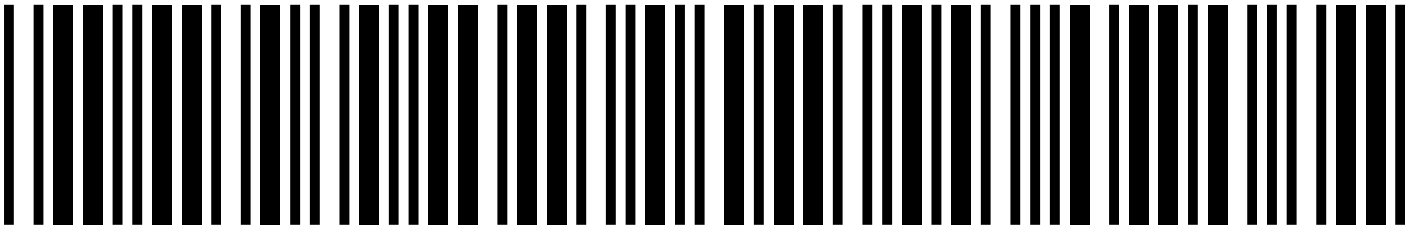
Author _____

Office Use Only

Received Date _____
MM/DD/YYYY

SAMPLE

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: PROOF OF SERVICE

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

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 _____

SAMPLE

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