How to file an appeal of the administrative director

Complete this form if you disagree with a determination made by the administrative director.

This form must be mailed to your local Workers' Compensation Appeals Board (WCAB) district office within 20 days after service of the determination by the administrative director. The service date can be found in the lower right hand corner of the determination.

Complete the form. Follow the attached sample(s). Explain in your own words why you disagree with the administrative director's determination. Sign and date the form. Complete the declaration of readiness to proceed to expedited hearing (see I&A guide 6). Complete the proof of service forms attached. You should also attach a copy of the administrative director's determination.

If you don't have a WCAB case, you also need to file an application for adjudication of claim (see I&A Guide 4), which opens a WCAB case for you.

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 Appeal of Determination of the Administrative Director)
- ✓ Appeal of Determination of the Administrative Director
- ✓ 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 13

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.

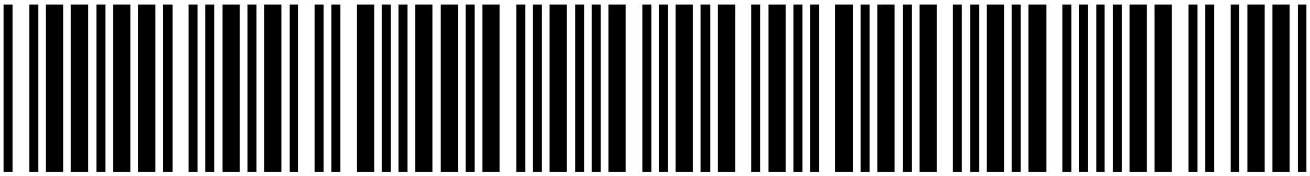
WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

ANAHEIM, 92806-2131 1065 North Link, Suite 170 Information & Assistance Unit **(714) 414-1801**	**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, 95501-0529 * 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) 482-3820**	**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, 92707-7704** 2 MacArthur Place, Suite 600 Information & Assistance Unit **(714) 942-7576**
OXNARD, 93030-7912 1901 N Rice Avenue, Suite 100 Information & Assistance Unit **(805) 485-3528**	**SANTA BARBARA, 93101-7538 * Satellite office *** 130 E Ortega Street 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 Floor, Suite 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

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

Case Number 2

☐ Specific 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)

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 Oxnard district office.

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

SAMPLE

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: APPEAL OF DETERMINATION OF AD-RSU

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

Author: YOUR NAME

Office Use Only

Received Date _____
MM/DD/YYYY

SAMPLE

NAME:
STREET:
CITY, STATE, ZIP CODE:

TELEPHONE #:

STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

YOUR NAME Applicant, vs. *YOUR EMPLOYER AND INSURANCE COMPANY* Defendants.	RSU Case # NOTICE OF APPEAL OF THE ADMINISTRATIVE DIRECTOR

EXPLAIN IN YOUR OWN WORDS WHY YOU DISAGREE WITH THE DECISION.

YOUR SIGNATURE

_____
Applicant

DATE MAILED

_____
Date

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

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