How to request an expedited hearing

File a declaration of readiness to proceed to expedited hearing when you need an expedited hearing on a claim that's been accepted. You can also use this form to request an expedited hearing if the insurance company hasn't approved medical treatment while investigating your claim.

The law requires the insurance company to authorize needed medical treatment within one working day after you submit a workers' compensation claim form, even while your claim is being investigated.

In addition to medical treatment, you can also request an expedited hearing at your local Workers' Compensation Appeals Board (WCAB) office to settle a disagreement about:

- Temporary disability or the amount of temporary disability payments
- Or when two or more employers argue over which one is liable for your benefit payments.

No matter what the problem, a hearing will only be set if you have an existing WCAB case number. If you do not have an existing WCAB case number, you also need to file an application for adjudication of claim (see I & A guide 4), which opens a WCAB case for you.

Complete the form using the attached sample as a guide. Check the issues being disputed. Provide a brief explanation of the issue or issues. Be sure to sign and date the form. File all supporting evidence with the form, including relevant medical reports. This form can also be completed at http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCCAForm10208_3.pdf.

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 Declaration of Readiness to Proceed to Expedited Hearing (Trial))*
- ✓ Declaration of Readiness to Proceed to Expedited Hearing (Trial)
- ✓ Document Separator Sheet (*for Proof of Service By Mail)*
- ✓ Proof of Service By Mail

Keep copies of your filings for your records.

All parties will be notified by mail when a hearing is set.

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.

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

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

EUREKA, 95501-0529 * Virtual office *
Information & Assistance Unit
(707) 441-5723

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

LODI, 95240-6936
3021 Reynolds Ranch Parkway, Suite 130
Information & Assistance Unit (209) 948-7980

LONG BEACH, 90810-1870
1500 Hughes Way, Suite C203
Information & Assistance Unit (424) 450-2565

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) 482-3820

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 Floor, Suite 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, 95110-3718
224 Airport Parkway, Suite 600
Information & Assistance Unit (408) 277-1292

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

SANTA ANA, 92707-7704
2 MacArthur Place, Suite 600
Information & Assistance Unit (714) 942-7576

SANTA BARBARA, 93101-7538
130 E Ortega Street
Information & Assistance Unit (805) 568-1390

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

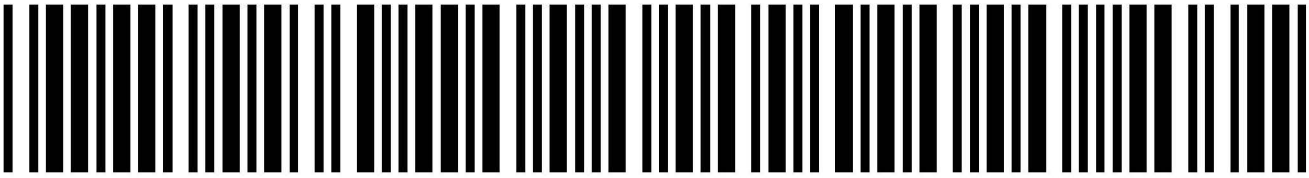
VAN NUYS, 91401-3370
6150 Van Nuys Boulevard, Suite 105
Information & Assistance Unit (818) 901-5374

Rev. 12/2023

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: _____

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
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

* Eureka is a virtual office.

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

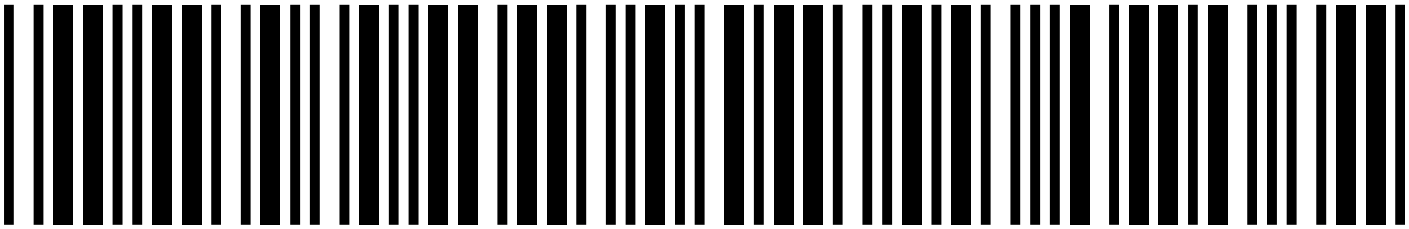
BODY PART CODES LIST

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: DECLARATION OF READINESS TO PROCEED TO EXPEDITED HEARING

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
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
DECLARATION OF READINESS
TO PROCEED TO EXPEDITED HEARING (TRIAL)
[Labor Code section 5502(b)]

SAMPLE

NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration.

EAMS CASE NUMBER

Case No.

Applicant

YOUR FIRST NAME

First Name

MI

YOUR LAST NAME

Last Name

VS

Employer Information

NAME OF THE COMPANY YOU WERE WORKING FOR AT TIME OF INJURY

Employer Name (Please leave blank spaces between numbers, names or words)

COMPANY ADDRESS

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

COMPANY CITY

City

State

Zip Code

The Declarant requests that this case be set for expedited hearing and decision on the following issues:

SELECT AT LEAST ONE

- ☐ Entitlement to medical treatment per Labor Code § 4600, except issues determined pursuant to Labor Code §§ 4610 and 4610.5.
- ☐ Entitlement to temporary disability, or disagreement on amount of temporary disability.
- ☐ Whether there is a properly established MPN in which the employee may obtain treatment. (If requested, this will be the only issue heard at the hearing.) See Labor Code §§ 4603.2(a)(3); 5502(b)(B).
- ☐ Entitlement to compensation is in dispute because of a disagreement between employers and/or carriers.

Declarant states under penalty of perjury that he or she has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed above:

LIST EFFORTS YOU HAVE MADE TO RESOLVE THE DISPUTE

Declarant states under penalty of perjury that there is a bona fide dispute; that he/she is presently ready to proceed to hearing; that his/her discovery is complete on said issues.

SAMPLE

Declarant's Signature YOUR SIGNATURE

IF YOU DO NOT HAVE AN ATTORNEY, PRINT YOUR NAME

Name of declarant or name of the law firm of the declarant (Print or Type)

YOUR MAILING ADDRESS

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

YOUR PHONE NUMBER

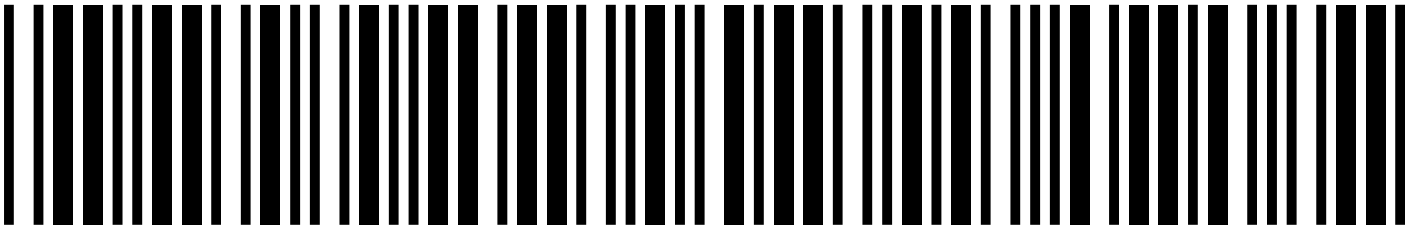
Phone Number

Date TODAY'S 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

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