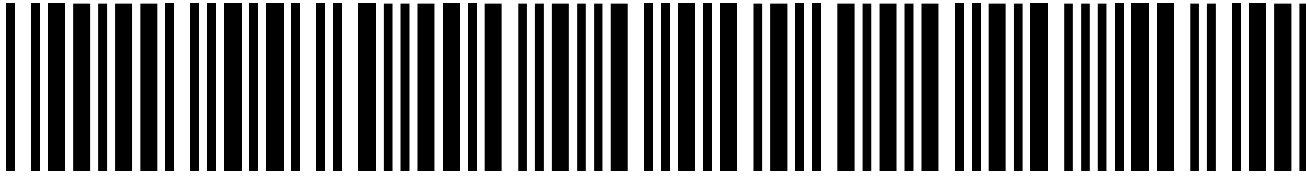


STATE OF CALIFORNIA  
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET



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

CHECK THE NO BOX

More than 15 Companion Cases

ENTER TODAY'S DATE

Date:(MM/DD/YYYY)

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

Specific Injury

ENTER THE EXISTING CASE NUMBER

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: \_\_\_\_\_

CHECK THE ADJ BOX

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

ADJ  DEU  SIF  UEF  SAU  INT  RSU

Companion Cases

Specific Injury

DO NOT ENTER COMPANION CASES

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: \_\_\_\_\_

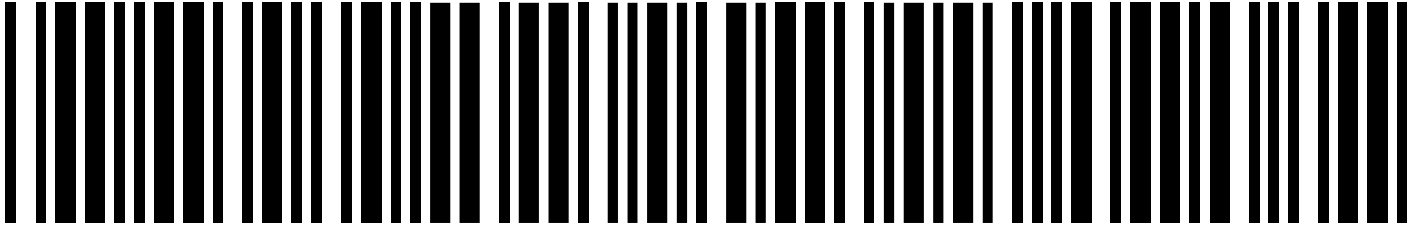
Body Part 3: \_\_\_\_\_

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

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

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

# DOCUMENT SEPARATOR SHEET



ENTER THE PRODUCT DELIVERY UNIT, DOCUMENT TYPE AND DOCUMENT TITLE SHOWN BELOW

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title AMENDED APPLICATION FOR ADJUDICATION

ENTER THE DATE OF THE DOCUMENT FOLLOWING THE DOCUMENT SEPARATOR SHEET

Document Date MM/DD/YYYY

ENTER UNIFORM ASSIGNED NAME IF A CLAIMS ADMINISTRATOR, LIEN CLAIMANT OR LAW FIRM. FOR ALL OTHERS, ENTER YOUR NAME

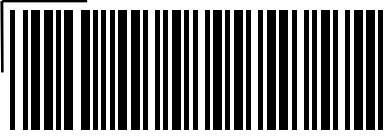
Author

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### Office Use Only

Received Date MM/DD/YYYY





**STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
APPLICATION FOR ADJUDICATION OF CLAIM**

Reset Form

Print Form

ENTER THE EXISTING CASE NUMBER

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

Amended Application

CHECK THE AMENDED APPLICATION BOX

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

SEE PAGE 6 FOR ADDITIONAL INSTRUCTIONS ON COMPLETING THIS FORM

**Venue choice is based upon (Completion of this section is required)**

- County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

VNO \_\_\_\_\_ 3 DIGIT OFFICE CODE MUST BE THE SAME AS THE CURRENT VENUE

Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

**Injured Worker (Completion of this section is required)**

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

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

1234 WILLOW RD \_\_\_\_\_  
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

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

VAN NUYS \_\_\_\_\_ CA \_\_\_\_\_ 91401 \_\_\_\_\_  
City State Zip Code

**Applicant (If other than Injured Worker)**

- Insurance Carrier
- Employer
- Lien Claimant

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

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

\_\_\_\_\_  
Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

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

**Employer Information (Completion of this section is required)** **MUST CHECK ONE BOX**

Insured       Self-Insured       Legally Uninsured       Uninsured

**COMPANY INJURED EMPLOYEE WORKED FOR AT TIME OF INJURY**

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

**COMPANY ADDRESS - MUST INCLUDE STREET ADDRESS OR PO BOX NUMBER**

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

**MUST INCLUDE CITY, STATE AND ZIP CODE**

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

**Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)**

**NAME OF EMPLOYER'S INSURANCE COMPANY**

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

**INSURANCE CARRIER'S ADDRESS - MUST INCLUDE STREET ADDRESS OR PO BOX NUMBER**

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

**MUST INCLUDE CITY, STATE AND ZIP CODE**

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

**Claims Administrator Information (If known and if applicable)**

**UNIFORM ASSIGNED NAME OF CLAIMS ADMINISTRATOR**

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

**CLAIM'S ADMINISTRATOR'S ADDRESS - MUST USE ADDRESS FOUND IN UAN DATABASE**

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

**MUST INCLUDE CITY, STATE AND ZIP CODE**

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

**IT IS CLAIMED THAT (Complete all relevant information):**

**INJURED EMPLOYEE'S DATE OF BIRTH**

1. The injured worker, born \_\_\_\_\_, while employed as a(n) \_\_\_\_\_  
(DATE OF BIRTH: MM/DD/YYYY) (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

specific injury \_\_\_\_\_  
suffered a : (Date of injury: MM/DD/YYYY)

cumulative injury which began on \_\_\_\_\_ and ended on \_\_\_\_\_  
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

The injury occurred at **ENTER INJURY LOCATION**

Street Address/PO Box - Please leave blank spaces between numbers, names or words

**MUST INCLUDE CITY, STATE AND ZIP CODE**

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

(State which parts of the body were injured)

Body Part 1: 420 BACK

Body Part 2: 100 HEAD

Body Part 3:

Body Part 4:

Other Body Parts:

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

ENTER ANY AMENDMENTS TO THE CASE IN SECTION 2

3. Actual earnings at the time of injury:

Rate of Pay \$ \_\_\_\_\_  Monthly  Weekly  Hourly State value of tips, meals, lodging, or other advantages, regularly received \$ \_\_\_\_\_  Monthly  Weekly  Hourly

Number of hours worked per week \_\_\_\_\_

DO NOT ENTER N/A OR UNKNOWN. LEAVE BLANK IF THIS INFORMATION IS UNAVAILABLE

4. The injury caused disability as follows:

Last day off work due to injury: \_\_\_\_\_ MM/DD/YYYY

First Period of Disability: Start Date \_\_\_\_\_ MM/DD/YYYY End Date \_\_\_\_\_ MM/DD/YYYY

Second Period of Disability: Start Date \_\_\_\_\_ MM/DD/YYYY End Date \_\_\_\_\_ MM/DD/YYYY

5. Compensation:

Compensation was paid:  Yes  No

Total paid: \_\_\_\_\_

Weekly rate(s): \_\_\_\_\_

Date of last payment: \_\_\_\_\_ MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury?  Yes  No

**7. Medical treatment:**

Medical treatment was received:

Yes  No

All treatment was furnished by the Employer or Insurance Carrier:

Yes  No

Date of last treatment: \_\_\_\_\_  
MM/DD/YYYY

Other treatment was provided/paid by: \_\_\_\_\_  
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

**Did Medi-Cal pay for any health care related to this claim?**

Yes  No

**Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:**

\_\_\_\_\_  
Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

**8. Other cases have been filed for industrial injuries by this worker as follows:**

\_\_\_\_\_  
Case Number 1

\_\_\_\_\_  
Case Number 3

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

\_\_\_\_\_  
Case Number 4

**9. This application is filed because of a disagreement regarding liability for:** **MUST SELECT AT LEAST ONE**

- |  |   |
|--|---|
| <input type="checkbox"/> Temporary disability indemnity    | <input type="checkbox"/> Permanent disability indemnity               |
| <input type="checkbox"/> Reimbursement for medical expense | <input type="checkbox"/> Rehabilitation                               |
| <input type="checkbox"/> Medical treatment                 | <input type="checkbox"/> Supplemental Job Displacement/Return to Work |
| <input type="checkbox"/> Compensation at proper rate       | <input type="checkbox"/> Other (Specify) _____                        |

Is the Applicant Represented?  Yes  No If "No", applicant is to sign and date below.

If "Yes", applicant's representative is to complete the following and is to sign and date below.

Law Firm/Attorney  Non-Attorney Representative

UNIFORM ASSIGNED NAME OF LAW FIRM IF APPLICANT IS REPRESENTED

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name MI

Attorney/Representative Last Name

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

City State Zip Code

MUST INCLUDE SIGNATURE WHEN APPLICANT IS REPRESENTED

APPLICANT MUST SIGN WHEN NOT REPRESENTED

Applicant Attorney/Representative Signature

Applicant Signature

Dated at \_\_\_\_\_, California

City

Date ENTER DATE ON SEPARATOR SHEET MM/DD/YYYY

# INSTRUCTIONS

**FILING AND SERVICE OF A DECLARATION OF READINESS IS A PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.**

## **Effect of Filing Application**

**Filing of this application begins formal proceedings against the defendant(s) named in your application.**

## **Assistance in Filling Out Application**

**You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.**

## **Right to Attorney**

**You may be represented by an attorney or agent, or you may represent yourself. The attorney's fee will be set by the Workers' Compensation Appeals Board at the time the case is decided and is ordinarily payable out of your award.**

## **Filling Out Application**

**For "amended" applications, the venue choice must be the same as that specified on the original application, unless an order changing venue has issued. A street or P.O. Box address within the United States must be entered for the place where the injury occurred. Therefore, if the injury did not occur at a fixed or identifiable location (such as a field, a highway, or on water), or if the injury occurred outside of the United States, the employer's business address or another appropriate address must be specified; however, a short explanation regarding the place of injury may be appended to the application. If medical treatment has been paid for by Medi-Cal, Medicare, group health insurance, or a private carrier, please specify.**

## **Service of Documents**

**Your attorney or agent will serve all documents in accordance with Labor Code section 5501 and the Workers' Compensation Appeals Board's Rules of Practice and Procedure.**

**If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.**

## **IMPORTANT!**

**If any applicant is under 18 years of age, it will be necessary to file a Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the district office of the Workers' Compensation Appeals Board, or by calling the district office and requesting this form.**

# Sample Proof of Service

[REDACTED]

### Proof of Service

I am at least 18 years of age, not a party to this action, and I am a resident of or employed in the county where the mailing took place.

My business address is: [REDACTED]

On [REDACTED] served a true copy of the following documents, along with supporting documents, described as: [REDACTED] by enclosing them in a sealed envelope addressed to each of the parties named and at the addresses set forth in the Party List, and placing each envelope for collection and mailing at the business address herein following our ordinary business practices, with postage fully prepaid, or by other previously agreed-upon method of electronic service.

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

Dated: [REDACTED]

Declarant Signature [REDACTED]

### Party List

[REDACTED]

RECEIVED

Example