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STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

SEE REVERSE SIDE FOR INSTRUCTIONS

WORKERS' COMPENSATION APPEALS BOARD

APPLICATION FOR ADJUDICATION OF CLAIM
(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. _____

M _____ _____
(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No. _____ _____

_____ _____
(APPLICANT. IF OTHER THAN INJURED EMPLOYEE) (APPLICANT'S ADDRESS AND ZIP CODE)
VS.

_____ _____
(EMPLOYER--STATE IF SELF INSURED) (EMPLOYER'S ADDRESS AND ZIP CODE)

_____ _____
(EMPLOYER'S INSURANCE CARRIER OR, IF SELF INSURED, ADJUSTING AGENCY.) (INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born _____ (DATE OF BIRTH), while employed as a _____ (OCCUPATION AT THE TIME OF INJURY)

on _____ (DATE OF INJURY) at _____ (ADDRESS) (CITY) (STATE) (ZIP CODE)
by the employer, sustained injury arising out of and in the course of employment to:

_____
(STATE WHICH PARTS OF THE BODY WERE INJURED)

2. The injury occurred as follows: _____
(EXPLAIN WHAT EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW INJURY WAS RECEIVED)

3. Actual earnings at the time of injury were: _____
(GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)

_____
(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)

4. The injury caused disability as follows: _____
(SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)

5. Compensation was paid ☐ (YES) ☐ (NO) $ _____ (TOTAL PAID) $ _____ (WEEKLY RATE) _____ (DATE OF LAST PAYMENT)

6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury ☐ (YES) ☐ (NO)

7. Medical treatment was received ☐ (YES) ☐ (NO) _____ (DATE OF LAST TREATMENT) All treatment was furnished by the Employer or Insurance Company ☐ (YES) ☐ (NO) Other treatment was provided paid by: _____
_____ Did Medi-Cal pay for any health care
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)
related to this claim? ☐ (YES) ☐ (NO) doctors not provided or paid for by employer or insurance company who treated or examined for this injury are _____
(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)

8. Other cases have been filed for industrial injuries by this employee as follows: _____
_____
(SPECIFY CASE NUMBER AND CITY WHERE FILED)

9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity _____
Permanent disability indemnity ☐ Reimbursement for medical expense ☐ Medical treatment ☐
Compensation at proper rate ☐ Rehabilitation ☐ Other (Specify) _____
AND APPLICANT REQUESTS A HEARING AND
_____
AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at _____ (CITY), California _____ (DATE)

_____ _____
(APPLICANT'S ATTORNEY) (APPLICANT'S SIGNATURE)

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS (DWC/WCAB Form 9) 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 fee will be set by the DWC at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

All blanks in the application shall be completed. Where the information is unknown, place "unknown" in the blank. If *medical treatment is paid for by Medi-Cal, Medicare, group health insurance or private carrier, please specify.*

Service of Documents

Your attorney or agent will serve all documents in accordance with Labor Code Section 5501 and Section 10500 of 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 office of the Workers' Compensation Appeals Board.