

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE
FOR INSTRUCTIONS

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)
VS.

(APPLICANT'S ADDRESS AND ZIP CODE)

(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 _____, while employed as a _____
(DATE OF BIRTH) (OCCUPATION AT TIME OF INJURY)

on _____ at _____
(DATE OF INJURY) (ADDRESS) (CITY) (STATE) (ZIP CODE)

By the employer sustained injury arising out of and in the course of employment to

(STATE WHAT PARTS OF BODY WERE INJURED)

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

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

(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEAL, 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 _____ All treatment was furnished by
(YES) (NO) (DATE OF LAST TREATMENT)

the Employer or Insurance Company _____ Other treatment was provided or paid for by _____
(YES) (NO)

(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE) Did Medi-Cal pay for any health care

related to this claim _____ doctor not providing or paid for by employer or insurance company who treated or examined
(YES) (NO)

for this injury are _____
(STATE NAMES AND ADDRESSES OFF 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: _____

(SPECIFIC 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 APPLICATION REQUESTS A HEARING AND AWARD OF

THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at _____ California _____
(CITY) (DATE)

(APPLICANT'S ATTORNEY)

(APPLICANT'S SIGNATURE)

(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)