How to file an application for adjudication of claim

Complete this form if you have a disagreement with your employer or its insurance company about your case and you want it resolved by your local Workers' Compensation Appeals Board (WCAB). Filing this form opens a case with the WCAB.

You can also complete this form if you think you may need the WCAB to resolve a dispute in the future and the time allowed for you to file the application could run out. If you have questions about whether time limits apply in your case, contact your local Information and Assistance office. You can get information on contacting a local I&A office on the Web at www.dwc.ca.gov.

Complete the form and follow the instructions attached. This form can also be completed at http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWC1.pdf.

Please note that a hearing in your case will not be scheduled until a declaration of readiness to proceed is filed (see I&A guide 5).

The following papers must be included with your completed application:

1. A copy of your claim for workers' compensation benefits (required only for injuries that happened between 1-1-90 and 12-31-93). See I&A guide 1.

2. Declaration required by law (Labor Code section 4906(h) -- see attached). A proof of service is recommended. See attached.

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 Application for Adjudication of Claim)*
- ✓ Application for Adjudication of Claim
- ✓ Document Separator Sheet (*for Proof Of Service By Mail)*
- ✓ Proof Of Service By Mail
- ✓ Document Separator Sheet (*for Declaration Pursuant to Labor Code Section 4906(h))*
- ✓ Declaration Pursuant to Labor Code Section 4906(h)

Keep copies of your filings for your records.

Information & Assistance Unit guide 4

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 claims administrator 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.

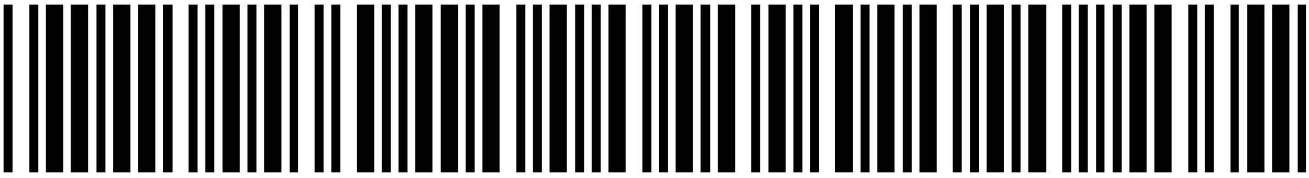
WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

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 * Virtual office * 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, 90810-1870 1500 Hughes Way, Suite C203 Information & Assistance Unit **(424) 450-2565**	**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

☐ 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
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.

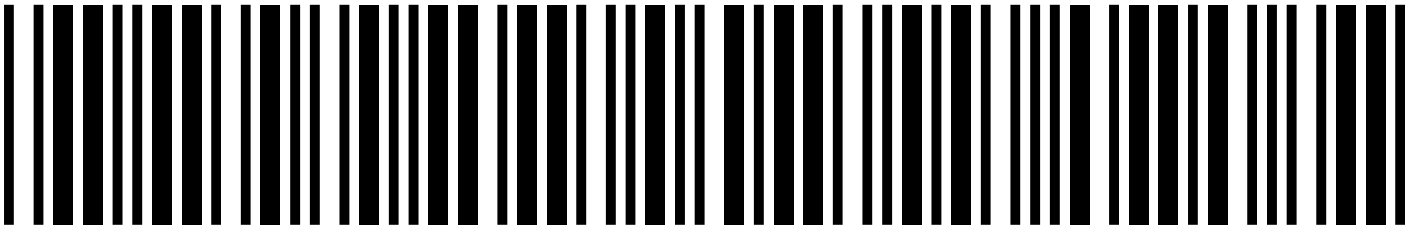
BODY PART CODES LIST

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: APPLICATION FOR ADJUDICATION

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

Author: YOUR NAME

Office Use Only

Received Date
MM/DD/YYYY

SAMPLE

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

LEAVE BLANK

Case No.

☐ Amended Application

YOUR SOCIAL SECURITY NUMBER

SSN (Numbers Only)

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).)

← SELECT ONE

USE 3 LETTER OFFICE CODE FROM DOCUMENT COVER SHEET

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

Injured Worker (Completion of this section is required)

YOUR FIRST NAME

First Name MI

YOUR LAST NAME

Last Name

YOUR MAILING ADDRESS

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)

YOUR CITY

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

SAMPLE

Employer Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

NAME OF 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

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

NAME OF COMPANY INSURANCE CARRIER

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

INSURANCE CARRIER ADDRESS

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

INSURANCE CARRIER CITY

City State Zip Code

Claims Administrator Information (If known and if applicable)

NAME OF CLAIMS ADMINISTRATOR

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

CLAIMS ADMINISTRATOR ADDRESS

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

CLAIMS ADMINISTRATOR CITY

City State Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born YOUR BIRTH DATE (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) YOUR JOB TITLE WHEN INJURED (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

☐ specific injury DATE OF ACCIDENT (Date of injury: MM/DD/YYYY)

suffered a :

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

The injury occurred at ADDRESS WHERE ACCIDENT TOOK PLACE

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

_____ , _____ _____ .

City State Zip Code

(State which parts of the body were injured)

SAMPLE

Body Part 1: PART OF BODY THAT WAS INJURED, USE LIST FROM DOCUMENT COVER SHEET

Body Part 2: _____

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)

INDICATE WHAT YOU WERE DOING AT THE TIME OF INJURY

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 _____

4. The injury caused disability as follows:

Last day off work due to injury: LAST DAY WORKED (MM/DD/YYYY)

First Period of Disability: Start Date FIRST DAY OFF WORK (MM/DD/YYYY) End Date DATE RETURNED TO WORK (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): FROM CLAIMS ADMINISTRATOR

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

SAMPLE

All treatment was furnished by the Employer or Insurance Carrier: ☐ Yes ☐ No

Date of last treatment: _____ MM/DD/YYYY

IF YOU OR PRIVATE INSURANCE PAID FOR MEDICAL TREATMENT

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:

LIST ANY OTHER CASES FILED WITH DWC

Case Number 1 _____ Case Number 3 _____

Case Number 2 _____ Case Number 4 _____

9. This application is filed because of a disagreement regarding liability for:

☐ Temporary disability indemnity
☐ Permanent disability indemnity
☐ Reimbursement for medical expense
☐ Rehabilitation
☐ Medical treatment
☐ Supplemental Job Displacement/Return to Work
☐ Compensation at proper rate
☐ 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.

SAMPLE

☐ Law Firm/Attorney ☐ Non-Attorney Representative

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

Applicant Attorney/Representative Signature

YOUR SIGNATURE

Applicant Signature

Dated at _____, California
City

Date TODAY'S DATE
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.

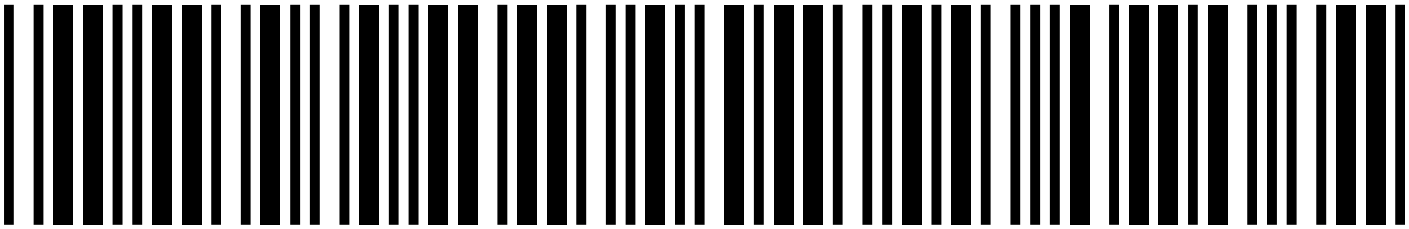
If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

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

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

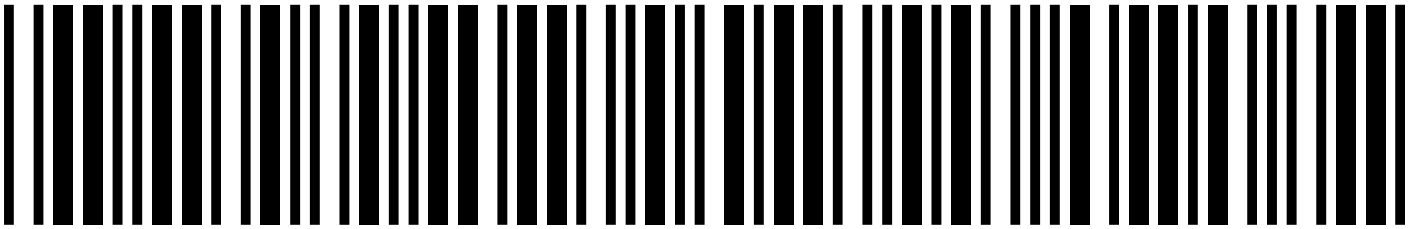
(date) TODAY'S DATE, at CITY, California.

Type or print name PRINT YOUR NAME

Signature SIGN YOUR NAME

SAMPLE

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: 4906(h) DECLARATION

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

Author: YOUR NAME

Office Use Only

Received Date: _____
MM/DD/YYYY

SAMPLE

DECLARATION PURSUANT TO LABOR CODE SECTION 4906(h)

Pursuant to Labor Code Section 4906(h), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Date: TODAY'S DATE

YOUR SIGNATURE

Signature

Before signing this form, you should be aware that: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."