

DWC-WCAB form 10214 (a) -1 Page 1 (Rev 5/2020)

STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD STIPULATIONS WITH REQUEST FOR AWARD



		Date of Injury		
Case No.			MM/DD/YYYY	
SSN (Numbers Onl	<u> </u> y)			
Venue Choice is b	ased upon: (Completion of t	his section is required)		
County of reside	ence of employee (Labor Cod	e section 5501.5(a)(1) or (d).)		
County where in	njury occurred (Labor Code se	ection 5501.5(a)(2) or (d).)		
County of princi	pal place of business of emplo	oyee's attorney (Labor Code section	5501.5(a)(3) or (d).)
Select 3 Letter Offic	e Code For Place/Venue of H	earing (From the Document Cover S	Sheet)	
Applicant (Comple	tion of this section is requir	red)		
First Name			MI	
Last Name			_	
Address/PO Box (F	Please leave blank spaces bet	ween numbers, names or words)		
City			State	Zip Code
Employer #1 Inforr	mation (Completion of this s	ection is required)		
Insured	Self-Insured	Legally Uninsured	Uninsu	red
Employer Name (P	lease leave blank spaces betw	ween numbers, names or words)		
Employer Street Ac	ddress/PO Box (Please leave	blank spaces between numbers, nan	nes or words)	_
City			State	Zip Code

surance Carrier Name (Please leave blank spaces between numbers, nan	nes or words)	_
surance Carrier Street Address/PO Box (Please leave blank spaces betwe	een numbers, names or words)	
ity	State	Zip Code
aims Administrator Information (if known and if applicable)		
ame (Please leave blank spaces between numbers, names or words)		
Street Address/PO Box (Please leave blank spaces between numbers, nam	nes or words)	_
Dity	State	Zip Code
mployer #2 Information (Completion of this section is required))	
Insured Self-Insured Legally U	Ininsured Uninsu	ured
Employer Name (Please leave blank spaces between numbers, nam	nes or words)	
Employer Street Address/PO Box (Please leave blank spaces betwe	een numbers, names or words)	
	een numbers, names or words) State	Zip Code
Employer Street Address/PO Box (Please leave blank spaces between City nsurance Carrier Information if known and if applicable - include even if carrier is adjusted by	State	Zip Code
City nsurance Carrier Information if known and if applicable - include even if carrier is adjusted by	State y claims administrator)	Zip Code
City nsurance Carrier Information	State y claims administrator) mes or words)	Zip Code

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

Name (Please leave blank spaces between numbers, names or words)		
Street Address/PO Box (Please leave blank spaces between numbers, names or words)		_
City	State	Zip Code
mployer #3 Information (Completion of this section is required)		
Insured Self-Insured Legally Uninsured	Unins	ured
Employer Name (Please leave blank spaces between numbers, names or words)		
Employer Street Address/PO Box (Please leave blank spaces between numbers, names o	or words)	
City	State	Zip Code
nsurance Carrier Name (Please leave blank spaces between numbers, names or words)		
nsurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or	words)	
	words) State	Zip Code
City		Zip Code
City Claims Administrator Information (if known and if applicable)		Zip Code
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or City Claims Administrator Information (if known and if applicable) Name (Please leave blank spaces between numbers, names or words) Street Address/PO Box (Please leave blank spaces between numbers, names or words)		Zip Code
Claims Administrator Information (if known and if applicable) Name (Please leave blank spaces between numbers, names or words)		Zip Code Zip Code

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Employer #4 Inforr	mation (Completion of this s	section is required)			
Insured	Self-Insured	Legally Uninsured	Unins	sured –	
Employer Name (P	lease leave blank spaces bet	ween numbers, names or words)			
Employer Street Ac	ddress/PO Box (Please leave	blank spaces between numbers, na	nmes or words)		
City nsurance Carrier I (if known and if ap		rrier is adjusted by claims admin	State	Zip Code	
Insurance Carrier Nai	me (Please leave blank spaces b	petween numbers, names or words)			
Insurance Carrier Stre	eet Address/PO Box (Please lea	ve blank spaces between numbers, nan	nes or words)		
City Claims Administra	tor Information (if known ar	nd if applicable)	State	Zip Code	
Name (Please leave l	blank spaces between numbers,	names or words)			
Street Address/PO Bo	ox (Please leave blank spaces be	etween numbers, names or words)			
City			State	Zip Code	
requirements of Lab	oor Code section 5313:	Award and/or Order, based upon th	ne following facts	, and waive the	
Employees Last	Name		,		
birth date	MM/DD/YYYY	- ,			
while employed at	: . <u></u>			,	State
as a(n)		Occupation		, Group	in
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nion Cases	1
Specific Injury	
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 2:	Body Part 3:
Other Body Parts:	
Specific Injury	
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 2:	Body Part 3:
Other Body Parts:	
Specific Injury	
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 2:	Body Part 3:
Other Body Parts:	
Specific Injury	
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 2:	Body Part 3:
Other Body Parts:	
	ustained injury(ies) arising out of and in the course of employme
(Please list all	body parts injured)
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	Specific Injury Body Part 2: Other Body Parts: Specific Injury Body Part 2: Other Body Parts: Other Body Parts: Specific Injury Body Part 2: Other Body Parts: Other Body Parts: Other Body Parts: Specific Injury Body Part 2: Other Body Part 2: Other Body Parts: Specific Injury Body Part 2: Other Body Parts:

2. The injury (ies) caused temporary disability for the period	through
for which indemnity has bee	en paid at \$ per week
2(a).The injury(ies) caused additional temporary disability for the	e period
	MM/DD/YYYY
through at the rate of \$	Rate in the amount of \$ Indemnity Paid
The injury(ies) caused permanent disability of	% for which indemnity is payable at \$ Indemnity Rate
per week beginning in the	sum of \$, less credit for such payments
previously made. And a life pension of \$Life Pension	_ per week thereafter.
An informal rating has / has not (Select one) been prev	viously issued in case no(s)
4.There is is Not a need for medical treatment to cure	or relieve from the effects of said injury (ies).
5. Medical-legal expenses and/or liens are payable by defendar	at as follows:
6. Applicant's attorney requests a fee of \$	
Fees to be commuted as follows:	
7. Liens Against compensation are payable as follows:	

9.Other stipulations:			
Dated	A 1: 4		
MIMI/DD/ f f f f	Applicant		
Applicant's Attorney or Authorized Representative:			ı
Law Firm/Attorney Non Attorney Representative		_	+
			1
First Name			
Last Name			
Firm Number			
Law Firm name			
Address/PO Box (Please leave blank spaces between numbers, names or words)		-	
City	 State	Zip Code	
Dated	Applicant Attorney C		_
MM/DD/YYYY	Applicant Attorney Sig	nature	1
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8. Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
First Name			
Last Name			
Firm Number			
Law Firm Name			
Address/PO Box (Please leave blank spaces between numbers, names or words)			
City	State	Zip Code	
Dated			
MM/DD/YYYY —————	Defense Attorney	Signature	
Defendant's Attorney or Authorized Representative:	<u> </u>		
Law Firm/Attorney Non Attorney Representative			
Law Fillin/ Montey Teprosoniative			
First Name			
Last Name			
Firm Number			
Law Firm Name			
Address/PO Box (Please leave blank spaces between numbers, names or words)			
City	 State	Zip Code	
	State	•	
Dated			
MM/DD/YYYY			
	Defense Attorne	ey Signature	

Defendant's Attorney or Authorized Representative:		
Law Firm/Attorney Non Attorney Representative		
First Name		ı
Last Name		
Firm Number		
Law Firm Name		
Address/PO Box (Please leave blank spaces between numbers, names or v	words)	
City	State	Zip Code
DatedMM/DD/YYYY	Defense Attorney S	Signature
Interpreter License Number:		
 Interpreter Name	Interpreter Lice	nse Number